

**THE INCIDENCE OF  
ADULT CHILDREN OF ALCOHOLICS  
IN A MIDWESTERN DIPLOMA SCHOOL  
OF NURSING**

A Thesis  
Presented to  
The College of Pharmacy and Health Sciences  
Drake University

In Partial Fulfillment  
of the Requirements for the Degree  
Masters of Science in Nursing

by

Phyllis Swanson  
February 1992

1992  
.524  
c.2

ABZ-8228

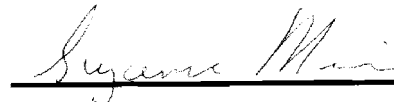
**THE INCIDENCE OF ADULT CHILDREN OF ALCOHOLICS  
IN A MIDWESTERN DIPLOMA SCHOOL OF NURSING**

by  
Phyllis Swanson

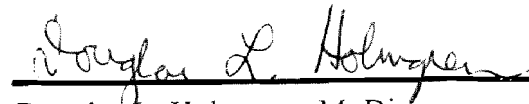
Approved by Committee:



Linda H. Brady, R.N., Ph.D., Chairperson



Suzanne Mains, R.N., M.S.



Douglas L. Holmgren, M. Div.

## TABLE OF CONTENTS

List of Figures and Tables	iii
Acknowledgements	vi
Abstract	vii
CHAPTER	
I. Introduction	1
Background	1
Purpose	10
Definitions	10
Significance of Study	11
II. Review of the Literature	12
Overview of Adult Children of Alcoholics	12
Developmental Theory	16
Description of Tool	26
Previous Studies	27
Incidence of ACOAs	27
Characteristics of ACOAs	28
Coping Behaviors	31
Substance Use Among ACOAs	34
Incidence in the Helping Professions	37
Need for the Study	38
III. Methodology	41
Subjects and Sampling Method	41
Description of the Instrument	41
Description of Data Gathering Procedures	42
Ethical Considerations	44

IV. Analysis	45
Descriptive Data	45
Identification of C.A.S.T. Scores	47
Analysis of C.A.S.T. Scores	60
Drinking Patterns	62
Concern Over Personal Drinking	62
 V. Discussion	 63
C.A.S.T. Scores	63
Drinking Patterns	65
Drinking Concern	66
Implications for Nursing Practice	67
Limitations of the Study	72
Recommendations for Further Study	73
 References	 76
 Appendices	 
A. C.A.S.T.	81
B. Agency Consent	82
C. Consent for Tool	83
D. Questionnaire	84
E. Letter to Participants -- Students	85
F. Letter to Participants -- Faculty	86
G. List of ACOA Support Groups	87

**LIST OF FIGURES AND TABLES****Figure**

1	Age: Overall Sample	45
2	Age: Student Sample	46
3	Age: Faculty Sample	46
4	Marital Status	47
5	Distribution of C.A.S.T. Scores: Overall Sample	47
6	Distribution of C.A.S.T. Scores: Student Sample	48
7	Distribution of C.A.S.T. Scores: Faculty Sample	48
8	Parent Identified as Alcoholic: Overall Sample	49
9	Parent Identified as Alcoholic: Student Sample	49
10	Parent Identified as Alcoholic: Faculty Sample	49
11	Drinking Patterns	50
12	Drinking Patterns Related to Gender: Overall Sample	51
13	Drinking Patterns Related to Gender: Student Sample	51
14	Drinking Patterns Related to Gender: Faculty Sample	51

15	Drinking Patterns Related to Marital Status: Overall Sample	52
16	Drinking Patterns Related to Marital Status: Student Sample	53
17	Drinking Patterns Related to Marital Status: Faculty Sample	53
8	Drinking Patterns Related to Alcoholic Father: Overall Sample	53
19	Drinking Patterns Related to Alcoholic Father: Student Sample	54
20	Drinking Patterns Related to Alcoholic Father: Faculty Sample	54
21	Drinking Patterns Related to Alcoholic Mother: Overall Sample	54
22	Drinking Patterns Related to Alcoholic Mother: Student Sample	55
23	Drinking Patterns Related to Alcoholic Mother: Faculty Sample	55
24	Drinking Concern	55
25	Drinking Concern Related to Marital Status: Overall Sample	56
26	Drinking Concern Related to Marital Status: Student Sample	56
27	Drinking Concern Related to Marital Status: Faculty Sample	56
28	Drinking Concern Related to Alcoholic Father: Overall Sample	57
29	Drinking Concern Related to Alcoholic Father: Student Sample	57

30	Drinking Concern Related to Alcoholic Father: Faculty Sample	57
31	Drinking Concern Related to Alcoholic Mother: Overall Sample	58
32	Drinking Concern Related to Alcoholic Mother: Student Sample	58
33	Drinking Concern Related to Alcoholic Mother: Faculty Sample	58
34	Drinking Patterns Related to Drinking Concern: Overall Sample	59
35	Drinking Patterns Related to Drinking Concern: Student Sample	60
36	Drinking Patterns Related to Drinking Concern: Faculty Sample	60

### **Table**

1	Mean Score as Identified by Alcoholic Parent	61
---	--	----

## **ACKNOWLEDGEMENTS**

My sincere thanks and appreciation are given to the many individuals who assisted me in the educational process. My husband, Wayne, has always supported my choices and his patience and encouragement have been invaluable. My family as a whole has been supportive in various and unique ways. I have also been fortunate to have the encouragement of many relatives and friends. I am thankful to my committee members for their involvement, energy, and support. And finally I extend my sincere gratitude to Dr. Linda Brady for her patience, understanding, and guidance.



### **Abstract**

The purpose of this study was to determine the incidence of adult children of alcoholics (ACOA) among the students and faculty in a Midwestern diploma school of nursing. The sample included 201 students and 17 members of the faculty.

The instrument used was the Children of Alcoholics Screening Test (C.A.S.T.) (Jones, 1981). A questionnaire to elicit demographic and self-report data regarding the participant's marital status, drinking patterns and level of concern over personal drinking behavior was also administered.

Analysis indicated 23% of the overall sample were ACOA and 8% were children of problem drinkers. In the student sample, 23% were ACOA and 8% were children of problem drinkers; 29% of the faculty were ACOA and 6% were children of problem drinkers. The total C.A.S.T. (Jones, 1981) score was significantly greater in those subjects who identified either parent as alcoholic. Married subjects were significantly more concerned ( $p = .04$ ) about personal drinking patterns than were single or divorced subjects. There was also significantly greater concern about personal drinking patterns when a father was identified as alcoholic in the overall and faculty groups ( $p = .03$ ). Limitations of the study and recommendations for further research conclude the discussion.

## **CHAPTER ONE**

### **Introduction**

#### **Background**

The use of alcohol is widespread in our society. Some people believe that better living can be instantly achieved through chemicals. For many individuals, stress and anxiety are the emotional prices paid for career success in an upwardly mobile and competitive society. As economic, social and personal pressures increase, many individuals attempt to reduce internal discomfort by drinking alcohol. Some people are able to use alcohol without any problems (Harmsen, 1984), but for many individuals an indulgence in alcohol can lead to a psychological dependence and a physiological addiction to alcohol. This is the disease of alcoholism and the individual is termed an alcoholic (Black, 1981).

Alcoholism is one of the most widespread, destructive and costly health problems in the country today. As early as 1974, alcoholism, directly or indirectly, affected the lives of 36 million Americans (Sloboda, 1974). Today, in a typical American community, one in six families is affected by alcoholism (Black, 1981). It is impossible to estimate the cost of alcoholism in the human suffering that results from divorce, deserted families and psychological problems commonly found in the children of alcoholic parents (Sloboda, 1974).

Alcoholism is a disease of unknown origin that affects people in all walks of life: housewives, television stars, clergy, physicians, nurses, astronauts and even children. Alcoholism has no known cure, but is treatable. An average alcoholic is a man or woman with a family, job and responsibilities. Only 3% to

5% of people with alcoholism are represented by the stereotyped “Skid Row” drinker (Black, 1981).

There is no specific behavior typical of an alcoholic. Some alcoholics drink daily, others in episodic patterns; some have long intervals between drinking episodes, and others drink constantly; some alcoholics drink enormous quantities, and others do not; some alcoholics drink beer, others wine or whiskey, while others may drink a wide variety of alcoholic beverages. Alcoholics are people who are unable to control their drinking with any predictability, or whose drinking causes problems in major areas of their lives (Black, 1981). Alcoholism is a disease process that is characterized by repetitive abusive drinking, personality changes while drinking and a process that affects the entire family system (Bingham & Barger, 1985).

In the media, plays, jokes and cartoons, drinking is portrayed as humorous. However, in real life, excessive drinking is tragic. People who are intoxicated are generally not funny, but rather are pathetic, frightening, and deceitful. An alcoholic may not lie about anything else, but will always deny that there is any problem with alcohol. An alcoholic’s drinking becomes the family secret, and the children learn at a young age to conceal the parent’s drinking (Wegscheider-Cruse, 1989).

The deteriorating condition of the chemically dependent person is closely intertwined with what happens to the other family members. Therefore, the process of chemical dependency from the first experimental use to physical addiction has been described (Wegscheider-Cruse, 1989).

All drinking starts out as social drinking. If the individual discovers that the chemical can change how he or she feels, the individual may take a drink the next time a change of mood is wanted. These early experiences with alcohol are the beginning of a lifetime pattern of “social drinking” (Wegscheider-Cruse, 1989).

Ultimately, the individual may move from “learning” the effects of alcohol to “seeking” them whenever a change of mood is desired. Although the individual may drink to the point of intoxication, this is still considered social drinking. As time passes, the drinker may begin to consume larger quantities of alcohol and at more frequent intervals. While the mind is enjoying euphoria, the body is slowly adapting its chemistry, and the individual needs more alcohol to get the same effect, which is known as “tolerance.” Tolerance may be an early warning sign of serious difficulty (Wegscheider-Cruse, 1989).

A later, more serious warning sign is the beginning of “blackouts.” Blackouts are a chemically induced form of amnesia that occur with regular, heavy use of alcohol or other mood altering drugs. During a blackout the individual may talk and act normally, does not lose consciousness and may not appear intoxicated. At first, blackouts may last only a minute or two, but as dependency develops, entire evenings or longer time periods can be lost. As the disease makes headway, blackouts can last for two or three weeks (Wegscheider-Cruse, 1989).

With the onset of blackouts, the drinker is believed to be “dependent.” Once dependency has set in, drinking becomes a need. Dependency, however, is

still considered to be psychological. The person begins to be preoccupied with alcohol, sneaks drinks and uses time and money that may be needed for the family to buy alcohol. Drinking now causes family problems and the drinker begins to feel guilty and experiences a decrease in self-worth. Alcohol no longer makes the drinker feel “high” and the person drinks just to feel normal (Wegscheider-Cruse, 1989).

The next critical event is the loss of control over the ability to stop drinking after one drink. This is the beginning of the “addictive” phase, and people around the person become concerned, hurt and angry. The person may try to quit drinking, and may even stop for a short time, but usually ends up drinking again. This causes the drinker pain, and the drinker counteracts with the defenses of denial, avoiding, blaming, threatening, boasting, and making excuses. This behavior pattern, however, only causes more pain and a cycle of drinking and defensive activity begins (Wegscheider-Cruse, 1989).

The downward spiral of dependency and addiction continues. The drinker’s life revolves more and more around alcohol, even leading to hoarding and hiding alcohol. Most of the individual’s friends are lost, and the individual loses any remaining interest in outside activities. The person generally can’t work and drinking is no longer a matter of choice, but of need (Wegscheider-Cruse, 1989).

Prolonged, heavy drinking also affects the drinker’s body. The drinker becomes physically addicted, and experiences symptoms of convulsions, hallucinations, delusions, delirium and tremors when not consuming alcohol. At

this stage, the person continually looks for a drink, and drinks most of the day. Life as usual is no longer possible; maintaining an addiction becomes a full-time job. The person has lost everything, and is left with nothing but the pain (Wegscheider-Cruse, 1989).

Everyone whose life touches the alcoholic is in one way or another influenced by the disease, but the direct consequences of alcoholism fall on the members of the immediate family. The family cannot easily leave the person whose life is disrupted by drinking, so the individuals stay and adapt. There is, however, no healthy way to adapt to alcoholism. During the early years, when the person drinks socially, the family may experience occasional episodes of embarrassment or quarrels over the drinking behavior. As the dependent drinker spends less time at home, the family begins to feel threatened, afraid, confused and unable to trust or communicate with the person who drinks. As the person loses control over drinking, the family feels anger, bitterness, hurt, disgust, frustration and possibly even guilt for having such feelings. Family members may also experience the stress of worrying about the safety of the drinker (Wegscheider-Cruse, 1989).

As the illness progresses for the drinker, the family begins to feel helpless, frustrated and afraid for both themselves and the drinker. Trust decreases, and the family's contempt and embarrassment increases. The psychological symptoms of alcoholism spread contagiously to every member of the family. At some point, the family members realize it is necessary to assume responsibilities previously assumed by the drinking person. The family no longer has any fun,

and there is an increase in physical and emotional problems among the family members (Wegscheider-Cruse, 1989).

As the alcoholic gradually loses self-control, power over the family increases. The alcoholic's behavior sets the rules directly or indirectly that must be followed by family members regardless of how unreasonable or inconsistent the rules must seem (Beltsis & Brown, 1981). The family takes on a group identity which mirrors that of the alcoholic, and soon everyone is displaying the psychological symptoms of alcoholism (Wegscheider-Cruse, 1989).

Alcoholic families are governed by rules that are inhuman, rigid and unhealthy. These rules grow out of the alcoholic's personal goals, which are to maintain access to alcohol, avoid pain, protect defenses and finally, deny that any of these goals exist. These rules are:

1. The dependent's use of alcohol is the most important thing in the family's life.
2. Alcohol is not the cause of the family's problem.
3. Someone or something else caused the alcoholic's dependency.
4. The status quo must be maintained at all cost.
5. Everyone in the family must help the alcoholic.
6. No one in the family can talk about what is really going on or tell what they are feeling (Wegscheider-Cruse, 1989, pp. 81-83).

Not every family responds to alcoholism in the same way. The dynamics of

the family environment differ depending on whether one or both parents are alcoholic, the children's ages when the alcoholism becomes unmanageable, economic stability, and the availability and use of external support systems. However, many commonalities and identifiable patterns of adaptation to alcoholism exist. In general, the family atmosphere is characterized by chaos and unpredictability. Children may have difficulties mastering developmental tasks. In most alcoholic homes, alcoholism is a major secret. The secret is the focus of the family. The primary defense used to maintain the secret is denial. In some families the alcoholism is never admitted; in others it may be recognized, while the impact and the seriousness are denied or explained away as the result of other problems (Beletsis & Brown, 1981).

In an attempt to keep the secret, the alcoholic family becomes increasingly isolated and defensive. There is often a great deal of shame and fear, and instinctively, the family withdraws from friends, community, church, and health services. As the alcoholism progresses, there may be many job changes and frequent moves, furthering the sense of isolation and family tension (Beletsis & Brown, 1981).

In an alcoholic family, childhood is short or nonexistent. The child learns to "manage" the actions of others, always attempting to avoid a disaster. The child learns to parcel out feelings to avoid upsetting the alcoholic or being responsible for precipitating a drinking episode. Thus, the child's feelings, needs and behavior are dictated by the condition of the alcoholic. All members of the family struggle to find ways of controlling an uncontrollable situation (Beletsis &



Brown, 1981).

A healthy response to living in the unorganized system of the alcoholic family would be to be honest about the practical problems, mental confusion and emotional pain. Honesty, however, is hazardous for families of alcoholics. Instead, the family members adapt by hiding their feelings behind an artificial behavior pattern. Various roles are assumed by family members as a protection against pain. These roles, however, support the alcoholic's drinking (Wegscheider-Cruse, 1989).

One common role assumed for protection is that of the enabler. The enabler is the person closest to the alcoholic. This is generally the spouse of the alcoholic, but may be the oldest child, a roommate, lover, or parent. The involvement of the enabler increases as the alcoholic's drinking progresses. The role includes making excuses for the person's drinking and behavior, covering up for the alcoholic, and taking on more and more of the alcoholic's responsibilities. Enablers often have anger that they are unable to express. Unexpressed anger often causes the enabler to feel exhausted, which may also be denied (Wegscheider-Cruse, 1989).

Another survival role is that of the family hero. Typically, the hero is the oldest child. The hero is particularly concerned with what happens to the family. The hero feels obliged to correct the family problems, make up for the family's weaknesses, and heal the family's pain. In the normal course of growing up, the hero role models the enabler and could be called "the little enabler" (Wegscheider-Cruse, 1989).

The third role is the scapegoat. This child learns that one is not rewarded for who one is, but for how one performs. The scapegoat decides it is too much effort to work as hard as the hero to prove oneself worthy; therefore, the scapegoat pulls away from the family and finds a feeling of belonging somewhere else. The scapegoat may engage in behaviors such as leaving home, unplanned pregnancies, chemical abuse, or defiant behavior. The scapegoat's actions provide a distraction for the family (Wegscheider-Cruse, 1989).

The next role is the lost child. This child learns not to make close connections in the family because it is too painful. The lost child becomes a "loner," and is not given any attention by the family, either positive or negative. The lost child offers relief for the family because the family doesn't have to worry about this child (Wegscheider-Cruse, 1989).

A fifth role is that of the mascot. The mascot uses charm and humor to cover up hurt feelings and confusion. A mascot is generally the youngest child, is cute and fun to be around (Wegscheider-Cruse, 1989).

An only child in a family may take on parts of all the roles. The roles may occur simultaneously or alternately, but either way, the pain and confusion are overwhelming (Wegscheider-Cruse, 1989).

The longer an individual plays a role, the more rigidly fixed in it the person becomes; a family who gets help early in the progression of the illness sheds the roles more easily (Wegscheider-Cruse, 1989). Some of the survival roles are destructive and leaving the alcoholic environment does not change the role an individual has assumed. There are approximately 28 million adults who grew up

in alcoholic homes. A young adult child of an alcoholic (ACOA) may be busy making decisions about a career and is usually unaware of the negative effects of an alcoholic upbringing (Black, 1979). The individual, however, may be aware of an ability to take care of others, and choose a career where this is necessary. Some experts report a disproportionately high percentage of ACOAs in nursing programs (Fischer, 1988).

#### Purpose of this study

Despite the recognition of alcoholism as a family disease, most research in the area focuses on the alcoholic (Nardi, 1981). Studies on ACOAs are limited (Barnes, Benson & Wilsnack, 1979), and minimal studies have focused on nursing (Fisher, 1988). In a study conducted by Arneson, Schultz and Triplett (1987), it was found that nurses are not knowledgeable about the long-term effects of parental alcoholism. Many nurses did not know that ACOAs often have problems with chronic depression and addictive behaviors. The purpose of this study was to identify the incidence of ACOAs among instructors and students in one nursing program.

#### Definitions

For the purpose of this study, an adult child of an alcoholic (ACOA) is any individual age 18 or older who obtains a score of 6 or above on the Children of Alcoholics Screening Test (C.A.S.T) (Jones, 1981).

A child of an alcoholic (COA) is any child age 17 or younger with one or both parents being alcoholic.

### Significance of this study

A basic understanding of the roles and rules of the alcoholic family provides a background for understanding the adults who grew up in a system where they were never allowed to be children. This understanding provides insight into how ACOAs may continue to enact the roles learned as a child as they enter adult life as students. It can also explain why many ACOAs choose careers in helping professions that reinforce enabling characteristics (Wittman, 1990). If there is a significant incidence of instructors and students in nursing programs from alcoholic homes, it is important that they be identified so that educational and intervention programs can be implemented.

Faculty who are ACOA can increase their insight into their own behavior so that student ACOAs can be helped. Other faculty familiar with the problems of ACOAs can be aware of students with histories of parental alcoholism, and can help these students to recognize how their background may affect their professional and personal choices, decisions, and behaviors (Wittman, 1990). Many ACOAs are relieved when they are able to talk about the family secret and have the support of a concerned adult to help them validate their feelings and experiences (Woodside, 1986). Informed faculty can encourage students to take advantage of help for ACOAs offered through counseling centers, or organize self-help groups to assist students to identify issues and cope more effectively with the long-term residual effects of growing up in an alcoholic home (Wittman, 1990).

## **CHAPTER TWO**

### **Literature Review**

The literature review will begin with a discussion of adult children of alcoholics (ACOAs), followed by a brief overview of developmental theory. Previous studies will be discussed. A tool to measure the incidence of ACOAs will be described. A discussion of the need for this study will conclude the review.

#### Overview of Adult Children of Alcoholics

There are approximately 28 million Americans who grew up in alcoholic homes (Black, 1981). An accurate figure is difficult to determine due to the problem of denial on the part of both the alcoholic parent and the ACOA (Fischer, 1987/1988). ACOAs develop a variety of behaviors in an attempt to cope with parental alcoholism, such as care-taking or achievement-oriented activities. These behaviors may be translated later into a caregiving career such as nursing (Black, 1981; Wegscheider-Cruse, 1985).

Children of alcoholics grew up in an environment of anger, fear and frustration. While one or both parents were caught up in the compulsion of alcohol, the other parent, if not drinking, was consumed with the family's survival, and had neither the time nor energy to give emotional support to the child. Surrounded by denial, anger and frequently verbal, physical and/or sexual abuse, these children grew up confused, anxious, self-blaming, withdrawn, and insecure. Many ACOAs appear happy and show no problems. However, they are afraid, hurt and live with a code that tells them not to talk, feel or trust

(Hetherington, 1988).

Growing up in an alcoholic home affects an individual emotionally, intellectually and behaviorally. One of the most striking affective features of an ACOA is denial. Some ACOAs deny parental alcoholism itself, while others acknowledge alcoholism but do so without any real emotion. Denial is learned because it is the family system. Denial of feelings is also learned because emotions are equated with being out of control and irrational like the alcoholic parent (Cummings, 1989).

Another affective feature is alienation from others. ACOAs not only deny their own feelings, but their connections with others as well. ACOAs feel alienated, different and unacceptable, and doubt their capacity to love and be loved. ACOAs wonder whether they really care about others or whether others really care about them (Cummings, 1989).

A third affective feature of ACOAs is deprivation and rage. ACOAs may appear self-sufficient and mature, however, they actually feel inadequate and deprived. Eventually, feelings of deprivation result in rage, but anger, for ACOAs, tends to be equated with violence and recklessness. ACOAs do not always know whether they are angry, when they are angry, or how to be angry. In group settings, ACOAs may try to control others' expressions of anger and dissatisfaction, for fear the other people will lose control. Often ACOAs contain their anger in rage-filled thoughts and fantasies, which spill over into chronic discontent with, and criticism of, themselves and others. Occasionally, when stress is high, ACOAs may have an angry outburst, and even a brief episode of

rage. These uncharacteristic eruptions result in ACOAs feeling afraid they may become mentally ill (Cummings, 1989).

ACOAs also suffer from low self-worth, shame and guilt. ACOAs may present a competent exterior, but actually feel damaged and defective. An ACOA's outward maturity is praised and rewarded in school and society, but ACOAs talk about being "found out" or feel like a "sham" (Cummings, 1989).

Four aspects that characterize ACOAs' thinking have been identified: confusion about normality, extreme thinking, inverted identifications, and faith in will power. First, ACOAs have no role models of normality while growing up. Therefore, they look outside the home to learn about typical families. ACOAs turn to the media for clues, or develop idealized fantasies about the world (Cummings, 1989).

The second cognitive feature is thinking in extremes. ACOAs tend to think in black or white, all or none, or good or bad. Extreme thinking is due to ACOAs' denial of the extreme conditions in their childhood families. Extreme thinking often leads to disillusionment in themselves or others as the extreme standards ACOAs set for themselves are unattainable, and they believe few people are totally worthy or trustworthy. All-or-nothing thinking hinders ACOAs from solving problems, and therefore ACOAs see themselves as continually failing, even when they are doing well (Cummings, 1989).

A third cognitive characteristic is inverted identification. Inverted identification represents an attempt to be different from the impaired parent in an attempt to separate from the parent. Inverted thinking, however, binds ACOAs to

parents as much as if ACOAs were trying to emulate the parents; inverted thinking can cause compulsive behavior and a fear of developing a true identity (Cummings, 1989).

The fourth cognitive characteristic of ACOAs is faith in will power, or a sense of omnipotence. In contrast to their alcoholic parents, ACOAs believe they can control anything if they try hard enough. A sense of omnipotence allows ACOAs to have a sense of control and predictability. They feel they can make things better. When the results are unchanged, ACOAs blame themselves unjustly, which may develop in a faulty concept of their own powers and limitations (Cummings, 1989).

Behaviorally, ACOAs appear self-reliant, perfectionistic, and socially poised. In reality, ACOAs are somewhat secretive and detached, may abuse drugs or alcohol, or develop an eating disorder or other self-destructive behavior. ACOAs developed self-reliance out of the unreliability of their parents, and, as adults, often sacrifice their own needs for nurturance while continuing the childhood role of caring for others. ACOAs seek perfection in themselves and others, and feel measured by what they do rather than who they are. An inability to be perfect signifies imperfection and is devastating to ACOAs (Cummings, 1989).

Growing up in an alcoholic family, ACOAs were told there was nothing wrong with the family, and at the same time not to tell anyone about the parent's use of alcohol. The message not to talk taught ACOAs not only to keep the family affairs to themselves, but to hide facts from people and not to bring friends



home. As ACOAs matured, the habit of keeping secrets kept people at a distance, made ACOAs guarded and deprived ACOAs of the chance for genuine relatedness (Cummings, 1989).

In addition, ACOAs unconsciously sabotage relationships. ACOAs will withdraw from relationships or cause problems with people before disappointments happen. Withdrawing from others keeps ACOAs in control and prevents ACOAs from being hurt. Withdrawing, however, causes a self-imposed isolation. ACOAs' isolation in turn reinforces their feeling of being a misfit in society (Cummings, 1989).

ACOAAs also worry about the possibility of being an alcoholic themselves. One survey revealed that 65 % of all users of student mental health services who were concerned about their own drinking were ACOAs (Claydon, 1987).

### Developmental Theory

The performance of nursing students and instructors, both personally and professionally, is influenced by the individual's ability to manage the tasks of psychosocial development. Erikson's (1968) theory of psychosocial development provides a unique framework for understanding an individual's behavior (Wallhead, 1986), as well as providing a picture of the developmental tasks faced by ACOAs on college campuses (Landers & Hollingdale, 1988). No literature is available that describes instructors' development.

Erickson (1968) divided the human life span into eight stages of psychosocial development and suggested that each stage has a specific critical task. Erickson (1968) proposed that people must complete the tasks of one stage

before moving on to the succeeding tasks. The achievement of the critical task results in the acquisition of desirable personality traits and in social adjustment. Failure to accomplish the task results in undesirable traits and maladjustment. In addition, unsuccessful resolution of one stage may endanger the resolution of later stages. Subsequent events, however, may present new opportunities and the individual may accomplish the task later. The six stages and the tasks of each stage that should be mastered by the college student are:

Stage One -- Infancy	Trust versus Mistrust
Stage Two -- Early Childhood	Autonomy versus Shame and Doubt
Stage Three -- Play Age	Initiative versus Guilt
Stage Four -- School Age	Industry versus Inferiority
Stage Five -- Adolescence	Identity versus Confusion
Stage Six -- Young Adulthood	Intimacy versus Isolation

(Erikson, 1968).

Stage one: trust versus mistrust.

Trust is the cornerstone of a vital personality and may be defined as a trustfulness of others as well as a fundamental sense of one's own trustworthiness. Trust is learned when an infant's needs are met, and is not an achievement, but an ongoing process. If needs are frustrated more often than met, the infant will be disappointed and develop a sense of mistrust that will continue into adult life (Erikson, 1968).

In a family where the mother is an alcoholic, the mother-child relationship will be impaired, because the mother's primary emotional involvement is with

alcohol and the child's needs are secondary. At times the mother does not respond to the child's cries and a feeding may be missed, or the child left wet and cold for hours. The mother may be intoxicated and tend to the child in an improper manner. At other times the mother may be sick with the effects of alcohol, depressed and guilty, or resentful for having to care for a dependent infant. In either case, appropriate physical and emotional care are neglected (Beletsis & Brown, 1981).

If the father is an alcoholic, the mother may be preoccupied with problems in the marital relationship and concerned about alcoholism. The mother's energy may be directed toward parenting her husband and coping with fear and despair, resulting in tension and confusion. This inclination often results in the psychological abandonment of the child, or in inadequate and inconsistent caretaking. In some families, the mother may turn to the child as a source of comfort, a replacement for the emotional contact which has been lost or as a solution to the unresolvable problem of alcoholism (Beletsis & Brown, 1981).

If the mother is incapable of adequately mothering the child because of her own alcoholism or preoccupation with an alcoholic spouse, the child learns to expect inconsistency, inadequate care and general disorganization. The child may respond by withdrawing, lacking confidence or being overly rigid (Beletsis & Brown, 1981).

Consistent parental neglect at any stage in the child's development may result in an inability to trust and decreased confidence in self-worth. In the alcoholic family it is likely that trust will be betrayed repeatedly as the obsession

with alcohol increases. Unmet needs result in the child of the alcoholic (COA) remaining focused on the parent and an inability to experience the appropriate awareness of self as a distinct person. Before any awareness of alcoholism is present, the COA's actions and feelings are controlled to some degree by alcohol (Beletsis & Brown, 1981). When these children become adults, an impairment of basic trust is expressed as severe estrangement characterized by individuals who withdraw into themselves when under stress (Erikson, 1968).

Stage two: autonomy versus shame and doubt.

Trust is necessary for the growth of autonomy. Autonomy is characterized by demands for independence as the child begins to display qualities of will power and self-direction. When the task of autonomy is not mastered, the child develops inhibitions that lead to diminished self-confidence and reluctance to try new skills in later life. Without a sense of autonomy, the individual may feel habitually ashamed, apologetic, afraid and full of doubt (Erikson, 1968).

The kind and degree of a sense of autonomy that parents are able to give their children depends on the dignity and sense of personal independence the parents derive from their own lives (Erikson, 1968). In the alcoholic family, the parents' ability to provide fair and consistent discipline and flexible and loving direction necessary for a child's need for autonomy is severely impaired. For a COA, already adapted to the parents' needs, to unpredictable responses and to inconsistent physical treatment, the development of autonomy is almost impossible. The alcoholic is struggling daily with issues of impulse control and the nonalcoholic parent is struggling to control the alcoholic. For the child who is

still trying to differentiate from the parent, it is a time of great confusion. The child may develop a pattern of being eager to please and a compulsive need to do every thing correctly. In an alcoholic family, what is correct or pleasing when a parent is drinking, may elicit anger, shaming or punishment when the parent is sober. An alcoholic parent's response to the child's behavior is influenced more by impatience, guilt, or illness from drinking than the child's activity. In this inconsistent family the child may develop feelings of shame and doubt (Beletsis & Brown, 1981).

Stage three: initiative versus guilt.

Initiative is concerned with the resolution of the child's ambivalent feelings of love and hate for his or her parents. During this stage, the child begins to imitate behaviors of authority figures. An inner sense of direction and purpose is the desirable outcome of this stage. If the critical task is not successfully achieved, the result may be a lack of spontaneity and the appearance of a harsh and controlling conscience (Erikson, 1968).

Stage four: industry versus inferiority.

The fourth stage of Erikson's (1968) theory is centered around industry. During this stage, the child is actively involved in learning and practicing skills. As the child moves through this stage, the child develops a sense of pride and accomplishment in completing tasks. In addition, the child develops the ability to set realistic goals. Failure at this time leads to a sense of inadequacy and inferiority. A child who feels inferior becomes afraid of tasks and is reluctant to try new projects (Erikson, 1968).

In the alcoholic family, the child who is already vulnerable because of the incomplete earlier stages of development may have difficulty with initiative or industry. Parents may become so preoccupied with alcohol that they withdraw from care-taking completely, and expect a level of unreasonable self-sufficiency from the child. This forced maturity creates anxiety for the child. Instead of a smooth transition into self-sufficiency, the child is prematurely pushed into early ego development, and insecure independence (Beletsis & Brown, 1981).

By the time a child in an alcoholic family reaches school age, the confidence in self-control and the pleasure of increased initiative may be misshapen by feelings of anxiety and inferiority. The child's needs and behavior are dictated by the state of the family. Defensively, the child begins to "manage" the actions and responses of others and control becomes important. Outwardly, the child may appear responsible and mature; inwardly, the child has feelings of inadequacy, doubt and a sense of overwhelming responsibility (Beletsis & Brown, 1981).

Due to the unpredictable and chaotic family environment, embarrassment and shame prevent COAs from bringing friends to the house. Consequently, it is difficult for children to develop and maintain friendships. The important social skills and sense of comfort gained from peers is lacking, further hampering the completion of initiative and industry (Belitsis & Brown, 1981).

The development of initiative and industry is also hampered by the emphasis of denial as a major defense in the alcoholic family. The child's perceptions may often be contradicted by the parent, such as hearing the mother

blaming her husband's absence from work on the illness of the child. Therefore, COAs become unwilling to develop initiative or demonstrate mastery, when to do so may mean being blamed for events outside of the COA's control (Belitsis & Brown, 1981).

Stage five: identity versus confusion.

The growing and developing youth is now faced with the task of developing an identity. It is a time when a young person is concerned with who he or she is, as well as a time when the youth develops a sexual identity. Often, the young person discovers and identifies with a role model. Many of the previous tasks need to be reworked before the individual develops a final identity. Problems with sexual identity and delayed selection of an occupation are common manifestations of failure to resolve the critical tasks of this stage (Erikson, 1986).

Not trusting others, denying reality and "managing" the behavior and well being of others leave little time for self-exploration and psychological growth for COAs. In fact, the need to deny feelings and needs is a denial of self, and an avoidance of having an independent identity. The child of an alcoholic cannot manage to give up the confused role of a child and move toward adulthood (Beletsis & Brown, 1981).

Whether one or both parents is alcoholic, the obsession with alcohol makes it likely that neither parent has been available as an appropriate role model. The role reversals which have taken place since early childhood may result in an adolescent who appears overly mature and capable, but feels helpless and frightened. The young adult may identify with the alcoholic parent, become

delinquent and abuse drugs and alcohol. Some COAs may withdraw and avoid relationships, while others may rush into marriage, often choosing a mate who is an alcoholic (Beletsis & Brown, 1981).

Stage six: intimacy versus isolation.

The sixth stage, lasting from ages 20 to 40, is the stage of intimacy versus isolation. The task of this stage is to commit oneself to meaningful, loving relationships with others. When intimacy is not achieved, the individual avoids or retreats from emotional commitments in various ways, such as being aloof, fleeing relationships once they become intense, or being promiscuous. Avoidance behaviors have the effect of isolating the individual from closeness (Erikson, 1968).

For ACOAs, relationships abound with difficulty; trust and intimacy are avoided. There is often little previous experience with close peer relationships, and the long experience of denying feelings and needs does not permit reaching out for support or help. Concern for, and involvement with, the family leaves little time for the development of new ties and a social network. Many ACOAs report being extremely depressed, feel life is meaningless, and experience continuous feelings of inadequacy and failure (Beletsis & Brown, 1981).

Separating from one's family of origin, establishing a sense of competence in being independent, developing an identity in one's career and creating and maintaining satisfying intimate relationships are tasks necessary for successful completion of college (Jack, 1990). ACOAs may be handicapped in completing these tasks (Landers & Hollingdale, 1988). Some ACOAs adopt the role of



“hero” or “responsible one” and go to college, hoping thereby to heal their families of pain and shame, but inwardly ACOAs feel inadequate (Cummings, 1989). Many ACOAs report difficulty separating from parents. The student may be preoccupied with siblings who are still at home, or feel responsible for the alcoholic parent. The responsible student is torn between guilt and fear and a need to be away from the home environment, making it difficult to concentrate on academics (Beletsis & Brown, 1981; Landers & Hollingdale, 1988).

Because of previous rejection, hurt and abandonment, some college ACOAs feel unaccepted and alienated from other people (Jack, 1990). Other ACOAs isolate themselves from peers because of fear that no one will understand or listen to them (Landers & Hollingdale, 1988; Cummings, 1989). Many ACOAs have low self-esteem, complicated by feelings of shame and guilt for having caused the family problem and being unable to fix it. An ACOA cannot handle intimacy because of the fear of being hurt. The need to keep the family secret of alcoholism leads to more isolation and lack of trust. Often the self-reliant and mature exterior the ACOA projects is just a superficial layer disguising strong feelings of inadequacy (Jack, 1990; Cummings, 1989).

ACOAAs become depressed and do not understand why (Black, 1979). As students, ACOAs may have difficulty in academic settings that require interpersonal and technical skills, and may continue with destructive behavioral patterns which can affect their patients, peers, supervisors, and faculty (Wittman, 1990).

Jack (1990) writes that by the time an individual reaches college, the roles

of the alcoholic family have become so internalized that the student may have difficulty comprehending what is normal. ACOAs do not change roles just because they leave home. In fact, it is after they leave home that ACOAs realize the old methods of coping are no longer working to provide a sense of meaning to life. It is at this time that the effects of living in an alcoholic home begin to show (Black, 1979).

The role of the “family hero” is reinforced during nursing school and the individual develops “super-nurse” characteristics, which may lead to job burnout (Selbach, 1990). Also, the child who adopts the “responsible” role, may become an adult with a high need to control and an inability to solve problems (Haack, 1990). The tasks of separating from their parents, becoming independent, developing an identity and creating intimate relationships can be difficult for an individual raised in an alcoholic environment. Work on these tasks, as well as the demands of academic requirements, may precipitate an emotional crisis for the ACOA. This crisis is complicated for a nursing student, because of nursing's values and its reinforcement of assuming a dependent, nurturing, and all-giving caretaker role. Also, nursing education has traditionally reinforced a sense of perfection and excessive responsibility (Jack, 1990).

ACOA's are considered at high risk for developing alcohol-related problems (Bingham & Barger, 1985; Black, 1981; Woodside, 1986), and are four times more likely to become alcoholic than the general population (Woodside, 1986). Beginning around 1970, researchers have attempted to discover whether a predisposition to alcoholism is inherited. Both twin studies and adoption studies

indicate that individuals with alcoholic parents are more likely to become alcoholic than individuals with nonalcoholic parents (Cook & Fonataine, 1991).

The issue of the impaired nurse is serious because it is related not only to the professional life of the individual nurse but also to the ethical and humanistic care of patients (Haack & Harford, 1984). If the public interest is to be served, the profession must recognize and deal with the factors that contribute to chemical dependency in nursing (Caroselli-Karinja & Zboray, 1986).

Students' behaviors are important to nursing faculty because instructors support students in the development of skills basic to personal and professional competence. Personal and professional growth require an environment of trust. Faculty may find it difficult to establish trust with students who are unfamiliar with talking to, or seeking help from, others (Wallhead, 1986). Once trust is established, ACOAs can be taught communication and assertiveness skills, and can be helped to develop trust and improve their self-esteem (Tesson, 1990).

#### A Tool to Measure the Incidence of ACOAs

COAs or ACOAs that come to a professional's attention are often individuals who experience a problem. Pilat and Jones (1984/1985) write that it is important that professionals screen children and adolescents as the first step in identification of offspring of alcoholics. Therefore, they developed the "Children of Alcoholics Screening Test (C.A.S.T)" (Jones, 1981).

The C.A.S.T. was developed to aid in the identification of individuals who are living with, or have lived with, alcoholic parents (Jones, 1981). The C.A.S.T is a series of 30 questions that are answered by the subject as "yes" or "no"

during an administration time of approximately five minutes. The C.A.S.T. (Jones, 1981) can measure COAs and ACOAs attitudes, feelings, perceptions and experiences related to their parent's use of alcohol. The test items were formulated from real-life experiences that were shared by clinically diagnosed COAs during group therapy and from published case studies (Jones, 1981). The "yes" answers are totalled to yield a C.A.S.T. score; a score of 0 to 1 indicates no reported experience of alcohol misuse, a score of 2 to 5 represents children or adult children of problem drinkers, and a score of 6 or more indicates children or adult children of alcoholics (COAs or ACOAs). The items were derived from the clinical work of Jones and from published case studies on ACOAs. All items were judged to have face validity by a number of alcoholism counselors and ACOAs. A Spearman-Brown split-half reliability coefficient equal to 0.98 was computed with a random sample of 81 adults in a Midwestern urban area (Jones, 1981).

#### Previous Studies

Previous studies will be presented according to their focus. They will begin with the incidence of ACOAs. Characteristics of ACOAs will be described, followed by studies that discuss ACOA's coping behaviors and substance abuse. They will conclude with the incidence of ACOAs in the helping professions.

#### Incidence of ACOAs.

Pilat and Jones (1984/1985) administered the C.A.S.T. (Jones, 1981) to 174 students in gym classes in a large Midwestern high school. Returning a completed C.A.S.T. indicated the subject's permission to participate and the

students' names were not included on the inventory. The C.A.S.T. (Jones, 1981) was administered to all the students by the same person. The gym classes were heterogeneously composed of students from different academic achievement levels.

More than one fourth (27%) of the students who completed the study had C.A.S.T. (Jones, 1981) scores of 6 or above. An additional 17% tested in the category of children of problem drinkers. The school social worker did not indicate that any of these students had been referred for problems, and the academic records of the COAs show that these COAs did not have poor study habits or low scholastic achievements. This verifies the view that some COAs survive in an inconsistent family system by exercising control over the environment and by bringing pride to the family. However, despite the children's achievement, almost one out of five of these students had recently failed one or more classes, which could indicate that the students studied were being affected by some special stress, possibly parental drinking (Pilat & Jones, 1984/1985).

#### Characteristics of ACOAs.

Using the Eriksonian theory of ego development, Talashek (1987) studied the ego identities of adolescents with one alcoholic parent. The study compared two groups of adolescents who were matched by age, sex and socioeconomic status. The sample came from Alateen groups (a fellowship of young people whose lives have been affected by alcoholism in a family member or close friend) and selected area classrooms in a large Midwestern city.

The Ego Identity Scale (Rasmussen, 1964) was used to obtain a measure of

ego identity. The scale includes 72 items, each reflecting either positive or negative resolution for one of Erikson's first six psychosocial development stages. To prevent response set, half the items required a positive answer, and the other half required a negative answer. The content validity was established based on Erikson's (1968) criteria for development. Additional data were gathered about the participant's age, sex, religion, alcohol use, number of siblings, parental occupation and parental alcohol use (Talashek, 1987).

Talashek spoke to the Alateen and school groups informing them that limited research had been reported concerning children from alcoholic families. The participation was voluntary and anonymous. To control for reading differences, Talashek read each question aloud as the questionnaire and Ego Identity Scale were completed. After completing the questionnaires, the subjects were allowed to ask questions (Talashek, 1987).

The hypothesis, that adolescents with one alcoholic parent will score lower on the Rasmussen Ego Identity Scale than will a matched group of adolescents without an alcoholic parent, was tested using the paired-comparison *t*-test procedure with the alpha set at .05. The mean identity score of adolescents with one alcoholic parent was 45.5; for adolescents without an alcoholic parent, the mean ego identity score was 49.07. This difference reached statistical significance at  $p = .037$ . In addition, adolescents of alcoholic parents were significantly more likely to have experienced school absences of longer than two weeks' duration than were adolescents from nonalcoholic families (Talashek, 1987).

Berkowitz and Perkins (1988) compared the personality characteristics of late adolescent and young ACOAs with those of adolescents from nonalcoholic families. The extent to which personality differences are gender specific was examined. The data were derived from an alcohol survey conducted in the spring of 1984 at an undergraduate liberal arts institution with a predominately Northeastern, upper middle class student body.

The questionnaires were completed and returned anonymously and included measures of impulsiveness, self-depreciation, lack of tension, independence/autonomy, need for social support, directiveness, sociability and other-directedness. The survey instrument also assessed attitudes, behaviors, social ability and personal and familial experiences related to the use of alcohol, as well as demographic data. To avoid a sample bias, the entire population of first and second year students were included in the sampling frame. A total of 860 students responded, providing a response rate of 90%. The students were between the ages of 16 and 23 years of age, with the majority of students being between age 18 and 20. Virtually all students resided in campus housing (Berkowitz & Perkins, 1988).

Berkowitz and Perkins (1988) classified the respondents as COAs if they responded affirmatively to leading questions. Also Berkowitz and Perkins included 12 items from the C.A.S.T. (Jones, 1981). Two forms of short form personality inventories that had been used and validated in previous studies were selected to test a wide range of personality measures. Each personality measure contained from four to seven questions that were scored on a 4-point Likert type

scale ranging from 0 to 3. Within each scale, responses were summed to provide an overall score (Berkowitz & Perkins, 1988).

The results of Berkowitz and Perkins' (1988) study indicated that COAs may experience both adaptive and dysfunctional consequences of parental alcoholism, but these effects vary by the gender of the COA. Female COAs reported significantly greater self-depreciation than female peers without an alcoholic parent. Male COAs reported significantly greater independence/autonomy than did male peers whose parents were not alcoholic. The greater independence/autonomy reported by male COAs may indicate an adaptive response to parental alcoholism that has resulted in positive qualities useful in other endeavors, such as school or work (Berkowitz & Perkins, 1988).

#### Coping Behaviors of ACOAs.

Clair and Genest (1987) compared children with an alcoholic father with children of non-alcoholic parents to examine the roles of family environment, social support and coping behavior on current level of adjustment. The sample consisted of 30 offspring of alcoholic fathers, and 40 offspring of non-alcoholic parents. All individuals were between the ages of 18 and 23. A standard self report format was used to gather demographic data and to inquire about parental alcoholism. A Family Environment Scale (FES) (Moos & Moos, 1981, cited in Clair & Genest, 1987) was used to collect data regarding relationships, personal growth dimension and system maintenance dimension. Dimensions of Social Support (DSSS) (Cohen, 1977, cited in Clair & Genest, 1987) was administered to measure the informational and emotional support received by subjects when



each was between the ages of 13 and 18. A check list, *The Ways of Coping* (Folkman & Lazarus, 1980) was used to assess the coping strategies that subjects used to deal with problems resulting from their father's alcoholism. In addition, a *Depression-Proneness Scale* (DPRS) (Hughes, 1977) was used to assess for proneness to negative mood and the *Tennessee Self-Concept Scale* (TSCS) (Fitts, 1965, cited in Clair & Genest, 1987) was used to assess both positive and negative self-perceptions. The findings of this study indicated COAs had significantly lower scores on the FES than the comparison group on cohesion and intellect-cultural orientation and significantly lower scores on the conflict subscale. Informational support reported by COAs was significantly less than the comparison group (Clair & Genest, 1987).

A descriptive study by Scavnick-Mylant (1990) focused on the coping mechanisms of young ACOAs. Retrospective data related to methods of coping were obtained from a convenience sample of 30 individuals who were raised, but not presently living, in a home where one or both of the parents were alcoholic. Paternal alcoholism was most common. The subjects were between the ages of 18 and 28 and the mean age was 24 years. Eighty percent of the subjects were female, and the most frequent (33%) birth order was youngest. All of the participants were interviewed using a semistructured interview schedule to identify developmental changes among coping mechanisms and role patterns of young ACOAs. The *Jalowiec Coping Scale* (Jalowiec, Murphy & Powers, 1984) was administered to help measure the level and method of coping. The findings suggested a possible developmental delay in coping strategies used by ACOAs

---

and an inability to seek comfort and help from others (Scavnicky-Mylant, 1990).

Black, Bucky and Padilla (1986) compared adults raised in an alcoholic home with adults raised in a non-alcoholic home. The subjects were solicited by notices in magazines and journals written about alcoholism and alcoholics. The subjects included 409 adults who identified themselves as having been raised in a home with parental alcoholism. All of the subjects were 28 years of age or over; the mean age was 37. There were 152 males and 257 females; 346 of the subjects had an alcoholic father, 162 had an alcoholic mother and 99 of the subjects indicated that both parents were alcoholic. The sample was geographically representative of all parts of the United States, and included all educational and socioeconomic levels.

The comparison group included 179 subjects who identified themselves as not having been raised in an alcoholic home. There were 63 males and 116 females. As in the experimental group, the comparison group was representative of various geographical areas in the United States and reflected all educational and socioeconomic levels (Black et al., 1986).

The subjects were asked to complete a questionnaire that focused on the subject's perceptions of the following: 1) family history; 2) past and present drug and alcohol use; 3) problems growing up in an alcoholic home; 4) communication with others; and 5) physical and sexual abuse. The data were analyzed by means of frequency count, percentages, Chi-Square tests, *t* tests and *z* tests for proportionality. The results indicated that ACOAs reported highly significantly more frequent divorces, more deaths of siblings and family members and more

alcohol related deaths than the control group. Almost 37% of ACOAs described themselves as alcoholic compared to 9.5% of the control group (Black et al., 1986).

Black et als' (1986) study also indicated that ACOAs reported highly significantly less communication with parents, friends, teachers, counselors, clergy and friends' parents and significantly less communication with neighbors than the comparison group. ACOAs reported a highly significantly greater frequency of family arguments and violent behavior than the comparison group, a significantly higher frequency of problems as children, highly significantly greater difficulty with trust, identifying and expressing feelings and highly significantly more difficulty with dependency, putting self first, confusion, intimacy and depression than the comparison group. ACOAs also reported a significantly higher frequency of work-related problems and difficulty solving problems and taking responsibility than did the comparison group (Black et al., 1986).

#### Substance Use Among ACOAs.

In 1987, Claydon studied entering college freshmen to determine the relationship of parental alcoholism and the abuse of substances. The C.A.S.T. (Jones, 1981) was used to determine parental alcoholism and the subjects were asked whether they considered themselves to have a problem with alcohol or other drugs, or an eating disorder problem. An analysis of the surveys revealed that 14.2% of the sample had one or both parents with alcoholism. The findings supported that parental alcoholism significantly increased the likelihood of

substance abuse or an eating disorder (Claydon, 1987).

Haack and Harford (1988) examined the prevalence of family history for alcoholism and its relationship to alcohol consumption in a sample of 179 nursing students. The subjects were enrolled in a large Midwestern university. Data were collected through self-administered questionnaires which were distributed to groups of students during classroom time. The findings indicated that nursing students report a positive history for alcoholism that is comparable to other college students; however, Haack and Harford (1988) suggest the results may be limited due to the defense mechanism of denial. The study did indicate that daughters of alcoholic fathers reported significantly higher levels of alcohol consumption than students with an alcoholic relative other than father or than students from non-alcoholic families (Haack & Harford, 1988).

In a study with college freshmen, Rearden and Markwell (1989) examined drinking problems and self concept of college students raised in homes where alcohol was abused. The subjects were 148 college students enrolled in two sections of a required freshman level health class. The students ranged in age from 17 to 25, with a mean age of 19.2. Students were encouraged to participate, but were informed that participation was voluntary. The instruments used were the C.A.S.T (Jones, 1981), the MAST (Pushkash & Quereshi, 1980), and the Tennessee Self Concept Scale. The MAST is a 25 item questionnaire that elicits a person's drinking history and requires "yes" and "no" answers. The Tennessee Self Concept Scale consists of 100 self-descriptive statements which the subject uses to portray a picture of him/her self. The scale is self-

administering for either individuals or groups and can be used with subjects age 12 or older (Rearden & Markwell, 1989).

Students were classified as COAs if their C.A.S.T. (Jones, 1981) score was six or more and were considered showing signs of a drinking problem if their MAST (Pushkash & Quereshi, 1980) score was five or higher. The scope of scores on the C.A.S.T (Jones, 1981) was 0-30; 23% of the students had scores of six or more. The MAST scores ranged from 0-29; 31% of the subjects scored five or above. The correlation between C.A.S.T (Jones, 1981) and MAST (Pushkash & Quereshi, 1980) scores was not significant. Mean self-concept for the COAs was significantly lower than the mean for the children of nonalcoholics (Rearden & Markwell, 1989).

Knoblauch and Bowers (1989) studied problem drinking and an elevated need to control among ACOAs. Two-thirds of the freshmen class in a Northwestern University were selected as subjects by taking every two of three students from the freshmen class mailing list. A MAST (Selzer, 1971) was used to measure problem drinking and the Ego Grasping Orientation (EGO) (Knoblauch & Falconer, 1986) was selected to measure a need to control. The students completed the instruments and also reported on the drinking patterns of their parents. Both the two by six multivariate and the five by two post-hoc multivariate revealed significantly more problem drinking and an elevated need to control among college students ACOAs than non-ACOA college students. This study indicated that ACOAs have unique needs and could benefit from self-help

groups and problem drinking assessment skills (Knoblauch & Bowers, 1989).

Incidence of ACOAs in the helping professions.

Wittman (1990) surveyed undergraduate students in a Southwestern university to clarify the possible relationship between choice of college major and prevalence of parental alcoholism. One hundred and ninety Occupational and Physical Therapy (OT/PT) students were used as a representative sample of individuals selecting helping oriented, allied health careers. The comparison group consisted of 211 students majoring in marketing and music. The C.A.S.T. (Jones, 1981) was used as an aid to identify ACOAs. This study revealed a statistically significant increase in the prevalence of ACOAs in students majoring in OT and PT than students majoring in general college courses. Wittman (1990) suggests that the statistics may reflect a high rate of denial of the existence of alcoholism in the family and the actual incidence may be even higher. Wittman (1990) implies these results could be generalized to other groups of allied health students (Wittman, 1990).

Pilat and Jones (1984/1985) examined the incidence of parental alcoholism in a group of helping professionals in a large Midwestern city. The subjects were a group of experienced therapists, a group of social work and family therapy students and a group of miscellaneous health professionals. The subjects were enrolled in a course designed to teach helping professionals additional skills in working with families of alcoholics. All subjects anonymously completed the C.A.S.T. (Jones, 1981). Analysis of the C.A.S.T. (Jones, 1981) scores indicated 25.5% of the students, 28.4% of the experienced therapists and 46.2% of the

miscellaneous therapists were ACOAs.

### Need for the Study

Preparing students for their real world roles is a challenge nurse educators cannot take lightly. Nurses need to be prepared with the ability to think critically, solve problems and be creative. Teaching is more than transmitting a certain body of knowledge to students; it is motivating students to be responsible for meeting their own learning needs (Busl, 1981). Learning does not take place in isolation nor is it limited to the walls of the classroom. The lack of motivation to learn what is expected stems from many sources which may include impoverished oppressive learning situations, failure, defeat or lack of stimulation. Students usually endeavor to behave in ways that are consistent with their self image. Students who feel caught in a web of failure perceive that they are not going to be able to succeed or complete a task successfully. This dilemma presents a barrier for both the teacher and the students (Wong, Wong, & Mensah, 1982).

College student ACOAs may appear self-reliant and well adjusted and may not be seen in need of concern or empathy from faculty or counselors. They may, however, have difficulties centered around anxiety, social discomfort, depression or somatic complaints. The ACOA student may not make any connection between the complaints and problems in their family. If faculty members are uninformed about ACOA problems, or engulfed in the problems of being raised in an alcoholic home themselves, students may not receive the help needed. It is crucial that significant people in the student's environment at college have an understanding of the student's needs and act in a supportive manner, helping the

student to acknowledge the impact of alcoholism and to strengthen adaptive responses to the demands of college life (Jack, 1990).

Nurses are essential members of the health care team and are directly responsible to the consumer. The rising incidence of chemical dependency among nurses is not only a concern for the individual nurse, but also for the profession. Most important, it is of serious concern to the individual for whom the nurse is responsible (Certe-Guinan & Wait, 1991). Haack (1990) writes that there is an increased incidence of anxiety disorders in alcoholic families which may lead to addictive behavior in other family members. If the public interest is to be served, it is necessary for the profession to recognize and deal with issues that affect the health of nurses (Caroselli-Karinja & Zboray, 1986).

A significant incidence of students who grew up engulfed in the disease of alcoholism has enormous implications for nursing instructors who are uninformed about the unique characteristics of ACOAs (Heatherington, 1988). Also, instructors may be vulnerable and susceptible to the ravaging effects of parental alcoholism themselves (Wittman, 1990).

Since ACOA issues can be treated quite effectively, it is essential for instructors and counselors to understand the emotional consequences of being raised in an alcoholic family so that intervention and prevention strategies can be implemented (Black et al., 1986; Crawford & Phyfer, 1988; Haack, 1990; Landers & Hollingdale, 1988). Early identification and treatment of ACOAs can relieve distress and prevent possible future disability (Claydon, 1987).

Nursing faculty who are familiar with ACOA issues and dynamics can be



aware of students with histories of parental alcoholism and help ACOAs to recognize how being raised in an alcoholic family may affect the ACOAs professional and personal choices, decisions and behaviors, Faculty can encourage students to take advantage of services for ACOAs (Wittman, 1990), and implement basic assessment skills for problem drinking (Knoblauch & Bowers, 1989).

If being raised in an alcoholic family causes emotional and scholastic problems, administration and faculty must mobilize resources to counteract these devastating effects. A study that identifies that there is a significant number of instructors and students in nursing programs needs to be done as a first step in identifying individuals with the hidden pains of being raised in an alcoholic family.

## CHAPTER THREE

### Methodology

This was a basic descriptive study. The sample was the faculty and students of a diploma school of nursing in the Midwest.

#### Subjects and Sampling Method

A convenience sample of all the faculty and students enrolled in a Midwestern diploma program during the fall semester of 1991 was used. The subjects were all the students who attended the first day of school and chose to participate in the study and all the faculty members who attended the first faculty meeting and chose to participate in the study. The school had an enrollment of 221 students and 36 faculty members; the sample included 201 students and 17 members of the faculty. This was a response rate of 90.95% for the students and 47.22% for the faculty and an overall response rate of 218 or 84.82%. The students' ages ranged from 17 to 45. The faculty's ages ranged from 28 to 55. The majority of the students and faculty were white, middle class females.

#### Description of the Instrument

The instrument used was the "Children of Alcoholics Screening Test (C.A.S.T.)", which was developed by Jones in 1981 (Appendix A). The C.A.S.T. is a 30-item self-report inventory that can be used as an aid in identifying children or adult children of alcoholics (COA or ACOA). The C.A.S.T (Jones, 1981) deals with preadult and adult feelings, attitudes, behaviors and experiences relating to COAs or ACOAs parents' use of alcohol. The C.A.S.T (Jones, 1981) is a series of 30 questions that were answered by the

subject as “yes” or “no” during an administration time of approximately 5 minutes. The “yes” answers were totalled to yield a C.A.S.T. score; a score of 0-1 indicates no reported experience of alcohol misuse; a score of 2-5 represents children of problem drinkers; and a score of 6 or more indicates adult children of alcoholics (ACOA). Jones (1981) derived the items from his clinical work and from published case studies on ACOAs. All items were judged to be face valid by a number of alcoholism counselors and ACOAs. A Spearman-Brown split-half reliability coefficient equal to 0.98 was computed with a random sample of 81 adults in a Midwest urban area (Pilat & Jones, 1984/1985).

#### Description of the Data Gathering Procedures

Permission to conduct this study was obtained from the Human Subjects Research Review Committee at Drake University. The researcher obtained access to the Midwestern diploma program chosen for this study through communication with, and permission from, the human subjects committee at the medical center (Appendix B). Permission to use the C.A.S.T. (Jones, 1981) was granted with the purchase of the tool (Appendix C). The tools were administered by the director and assistant director of the program at a time and manner mutually acceptable to both the researcher and institution.

A questionnaire to obtain additional demographic and self-report data was also administered (Appendix D). This tool was used in order to investigate additional variables and their association with the scores on the C.A.S.T. (Jones, 1981). These variables consisted of the participants’s marital status, drinking patterns, and level of concern over personal drinking behavior.

The C.A.S.T. (Jones, 1981) (Appendix A) and self-report instrument (Appendix D) were administered to the students during the first class session of the fall semester. The tools were administered to the entire faculty during the fall reconvening faculty meeting. Cover letters accompanied the instruments (Appendices E and F). The cover letters contained words of thanks for participating in the survey, introductory comments about the nature of the study, instructions on how to complete the C.A.S.T. (Jones, 1981), an explanation of how anonymity would be maintained and information that the school would not be identified in any writings about the study. The subjects were assured that refusal to participate would not affect their jobs, grades or standing in the school in any way. Subjects were instructed that consent was given by completing and returning the questionnaires. The participants were also informed that the results of the study would be shared with the director of the program and with the participants at their request. The director and assistant director of the school read the cover letter as the faculty and students also read it. After the respondents and director or assistant director read the cover letter, the participants were given an opportunity to ask questions. No names or identification numbers linking names to the questionnaires were used. The faculty surveys were marked with an "F" and placed in an envelope marked "faculty" in order to separate the faculty data from the data of the students. The participants completed the instruments and, upon completion of the questionnaires, placed them in the envelopes provided. The director and associate director placed the envelopes in an identified box in the associate director's office. In addition, the participants were given a list of

current ACOA support groups (Appendix G). The tools were picked up by the researcher at the completion of the data-collecting process.

### Ethical Considerations

Permission to conduct this study was obtained from the Human Subjects Research Review Committee at Drake University and the Human Subjects Committee at the medical center (Appendix B). Permission to use the C.A.S.T. (Jones, 1981) was granted upon purchasing the tool (Appendix C). The faculty and students were informed they were participating in a study that was designed to determine family drinking patterns, and that all the information would be anonymous. Also, the participants were informed they would not experience any harm and no repercussions would be experienced if they chose not to participate. A list of meeting times and places of ACOA support groups (Appendix G) was given to the participants in case participating in the study created an awareness of any problems caused by family patterns of drinking.

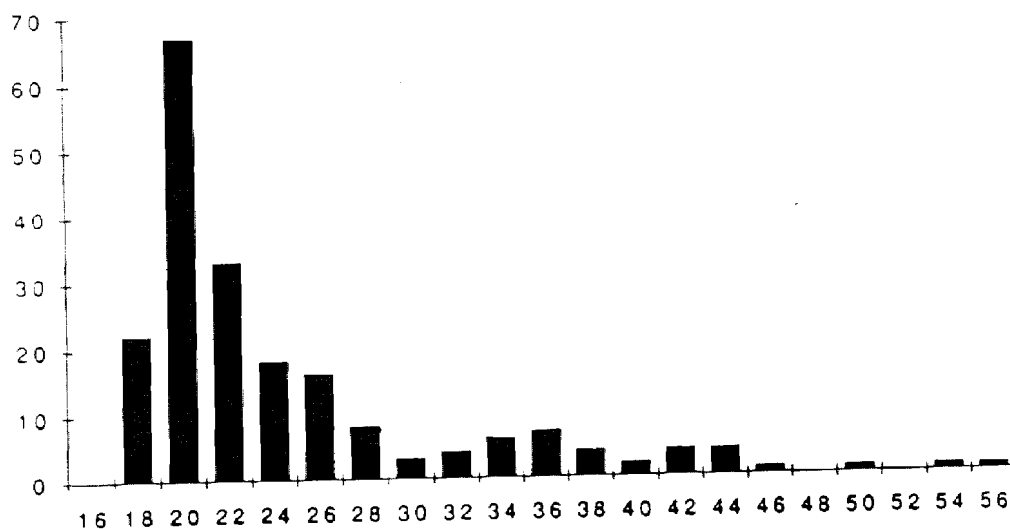
## CHAPTER FOUR

### Analysis

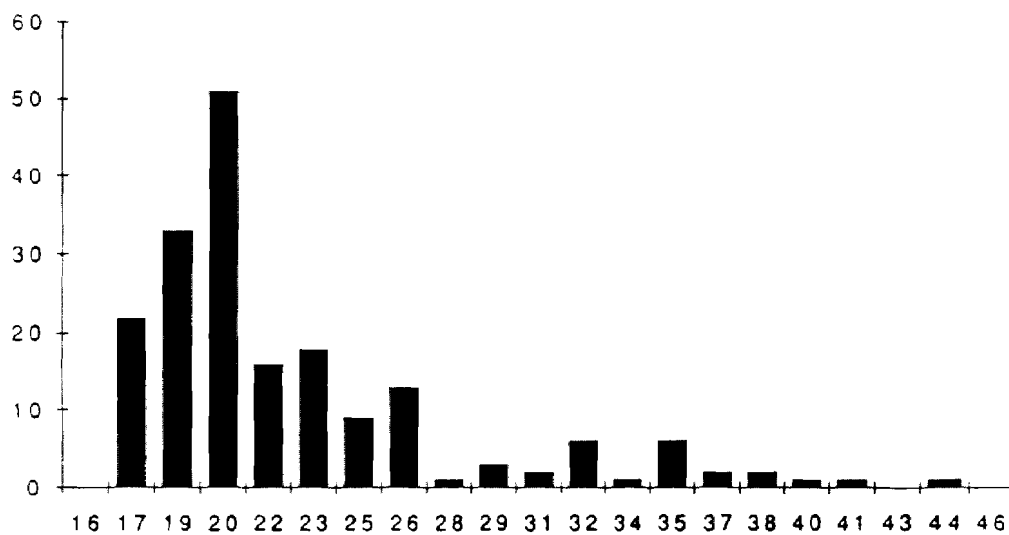
It is important, both personally and professionally, that individuals who are affected by an alcoholic environment be identified.

The participants who were present and chose to participate in the surveys included 201 students (90.95%) and 17 (47.22%) faculty members, for a total response rate of 218 (84.82%). All of the faculty and 188 of the students were female; 13 students were male. Participants who did not include all the demographic or self-report data were included in the study if the C.A.S.T. (Jones, 1981) was completed. The participant's age and marital status is represented in Figures 1 to 4.

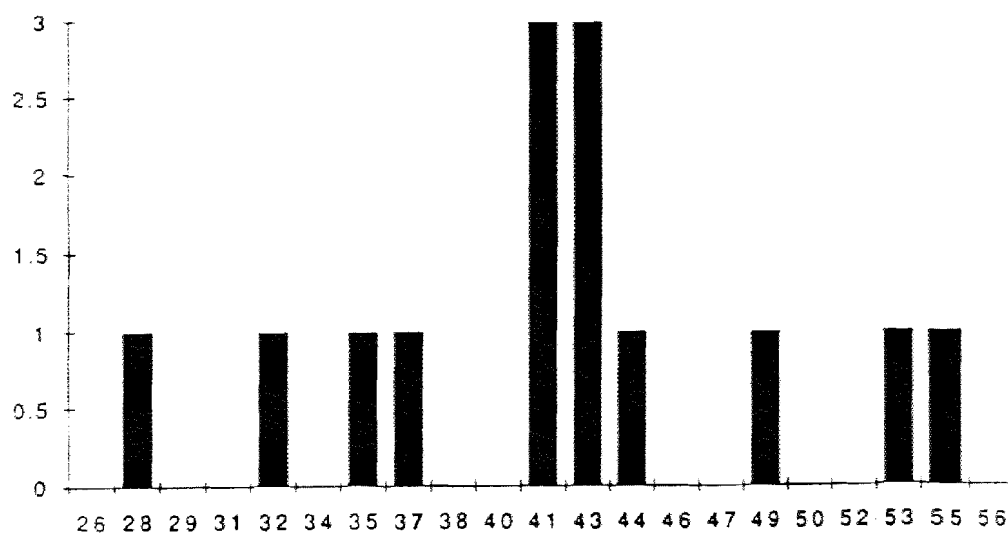
*Figure 1. Age: Overall Sample*

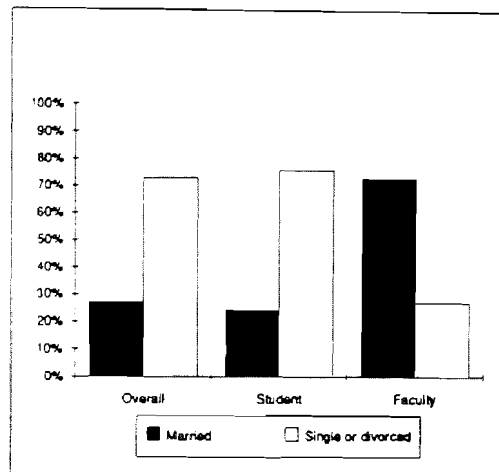


*Figure 2. Age: Student Sample*



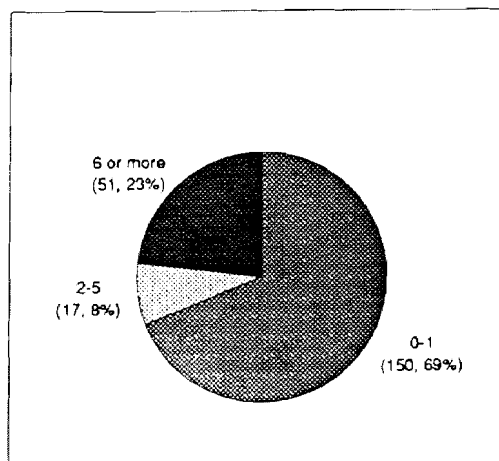
*Figure 3. Age: Faculty Sample*



*Figure 4. Marital Status*

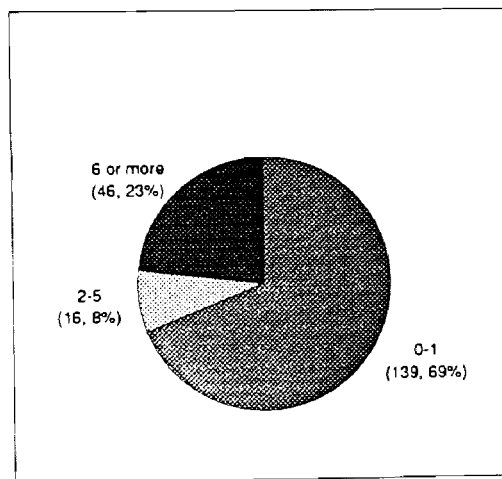
#### Identification of C.A.S.T. Scores

The data were identified according to the score on the C.A.S.T. (Jones, 1981). Jones (1981) suggests categorizing the scores according to 0-1, 2-5, and 6 or more. A score of 0-1 indicates no reported experience of parental alcohol misuse; a score of 2-5 represents children of problem drinkers; a score of 6 or greater indicates adult children of alcoholics (ACOAs). This data is represented by Figures 5 to 7.

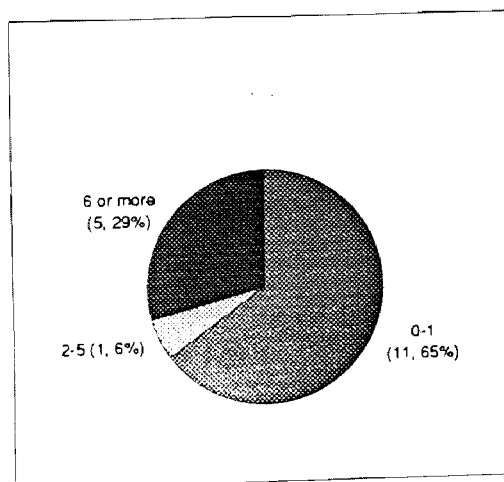
*Figure 5. Distribution of C.A.S.T. Scores: Overall Sample*



**Figure 6. Distribution of C.A.S.T. Scores:  
Student Sample**

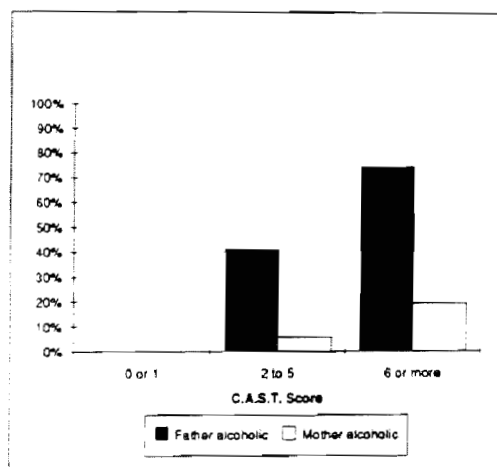


**Figure 7. Distribution of C.A.S.T. Scores:  
Faculty Sample**

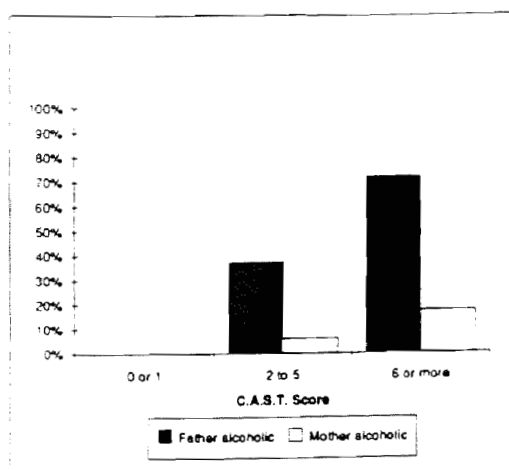


Question number 22 of the C.A.S.T. (Jones, 1981) asks "Did you ever think your father was an alcoholic?" Question number 25 asks "Did you ever think your mother was an alcoholic?" Figures 8 to 10 illustrate the percentages of respondents who responded in the affirmative to one or both of these questions.

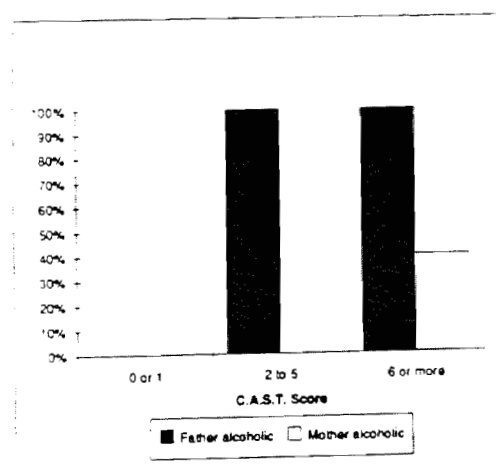
**Figure 8.**  
*Parent Identified as Alcoholic:*  
*Overall Sample*



**Figure 9.**  
*Parent Identified as Alcoholic:*  
*Student Sample*

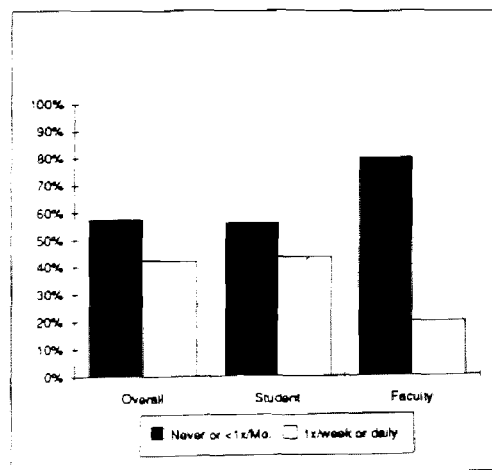


**Figure 10.**  
*Parent Identified as Alcoholic:*  
*Faculty Sample*

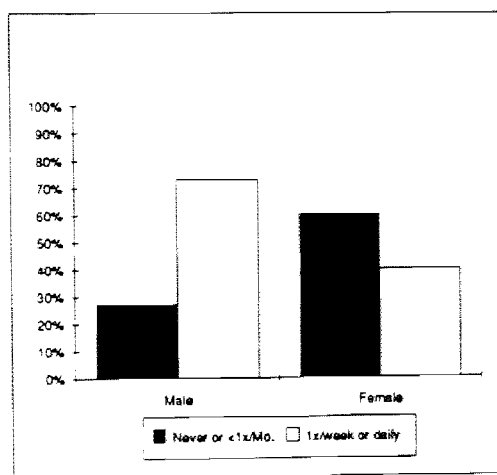


The participants indicated their gender on the C.A.S.T. (Jones, 1981). Using the demographic sheet, the participants were classified according to drinking patterns (Figure 11). Figures 12 to 14 illustrate drinking patterns according to gender.

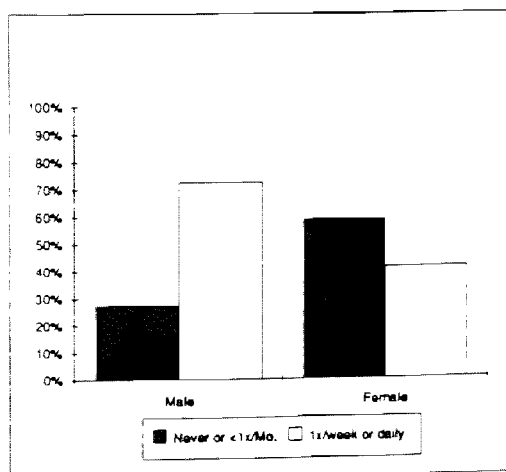
*Figure 11.  
Drinking Patterns*



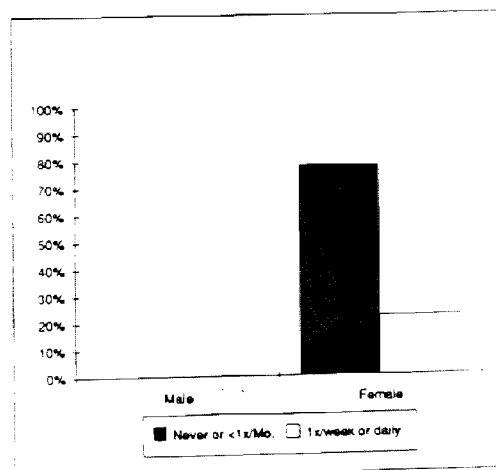
**Figure 12.**  
**Drinking Patterns Related to**  
**Gender:**  
**Overall Sample**



**Figure 13.**  
**Drinking Patterns Related to**  
**Gender:**  
**Student Sample**

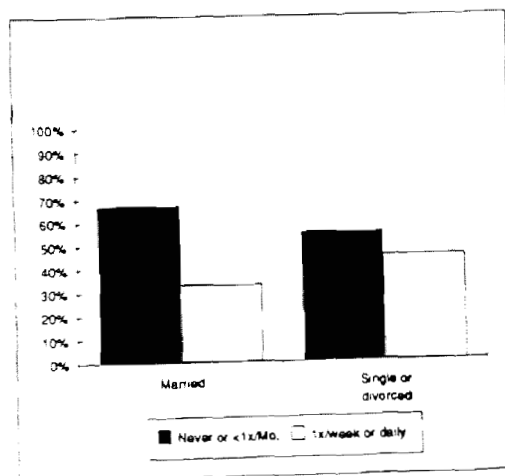


**Figure 14.**  
**Drinking Patterns Related to**  
**Gender:**  
**Faculty Sample**

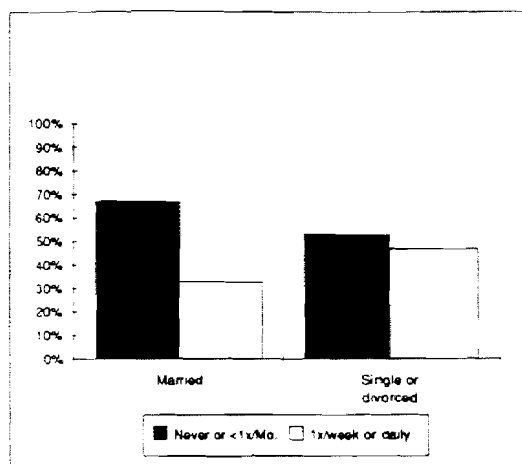


In addition, the participants' drinking patterns were identified according to marital status and identification of an alcoholic parent (as identified in response to questions number 22 or 25 on the C.A.S.T.) (Jones, 1981). These data are represented in Figures 15 to 23.

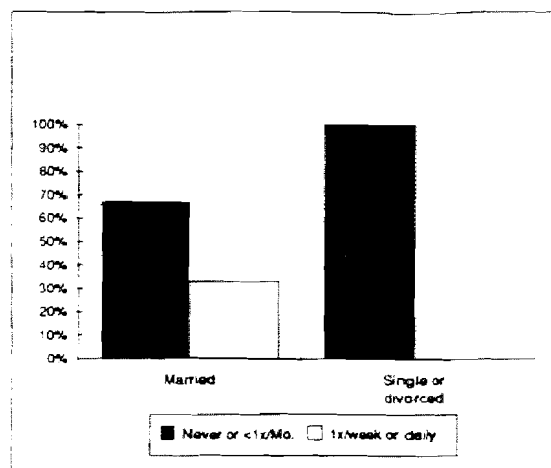
*Figure 15.  
Drinking Patterns Related to  
Marital Status:  
Overall Sample*



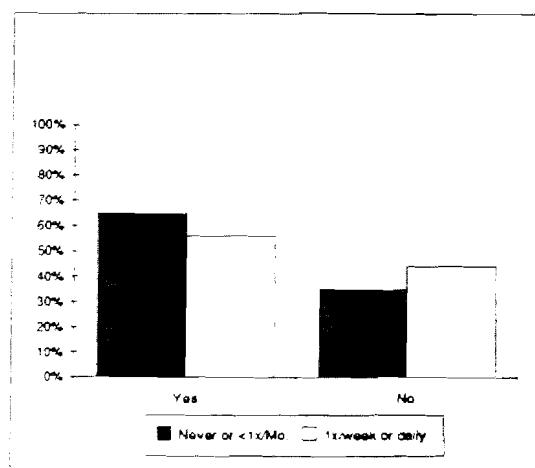
**Figure 16.**  
**Drinking Patterns Related to**  
**Marital Status:**  
**Student Sample**



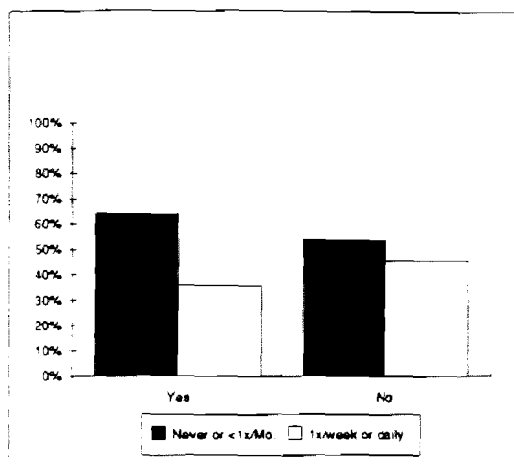
**Figure 17.**  
**Drinking Patterns Related to**  
**Marital Status:**  
**Faculty Sample**



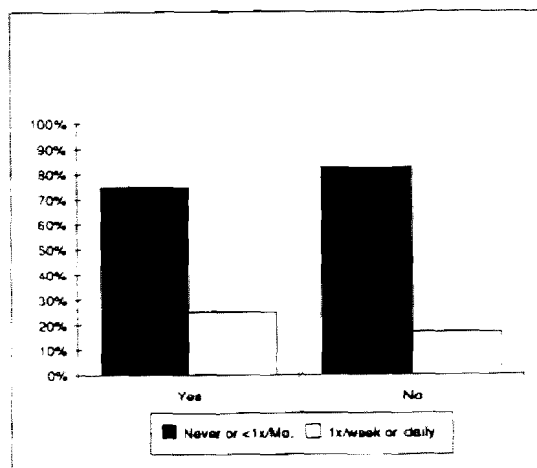
**Figure 18.**  
**Drinking Patterns Related to**  
**Alcoholic Father:**  
**Overall Sample**



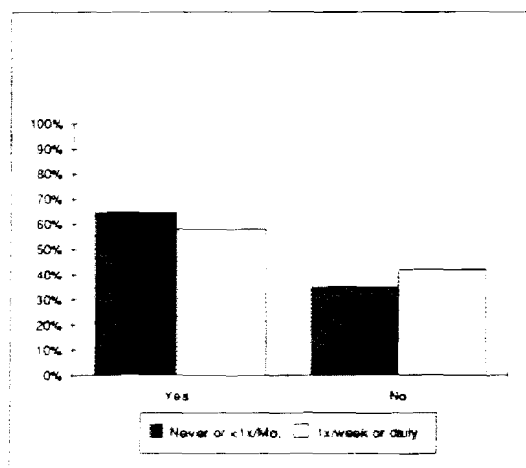
**Figure 19.**  
**Drinking Patterns Related to**  
**Alcoholic Father:**  
**Student Sample**



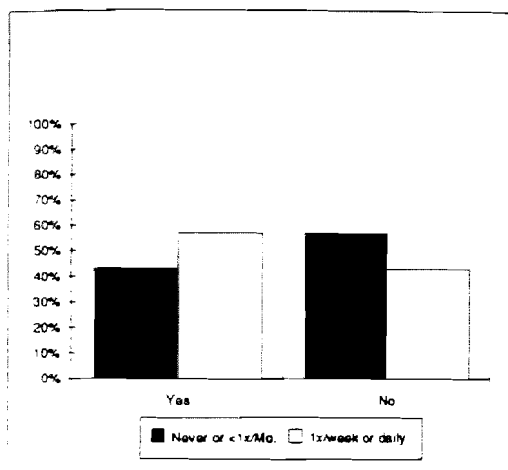
**Figure 20.**  
**Drinking Patterns Related to**  
**Alcoholic Father:**  
**Faculty Sample**



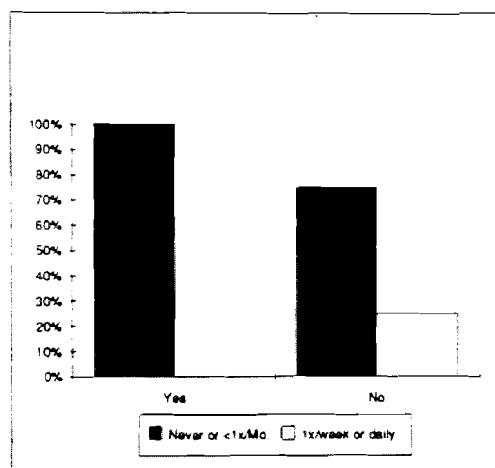
**Figure 21.**  
**Drinking Patterns Related to**  
**Alcoholic Mother:**  
**Overall Sample**



**Figure 22.**  
**Drinking Patterns Related to**  
**Alcoholic Mother:**  
**Student Sample**

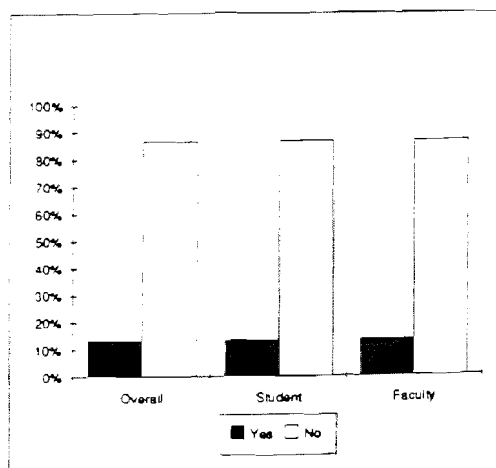


**Figure 23.**  
**Drinking Patterns Related to**  
**Alcoholic Mother:**  
**Faculty Sample**



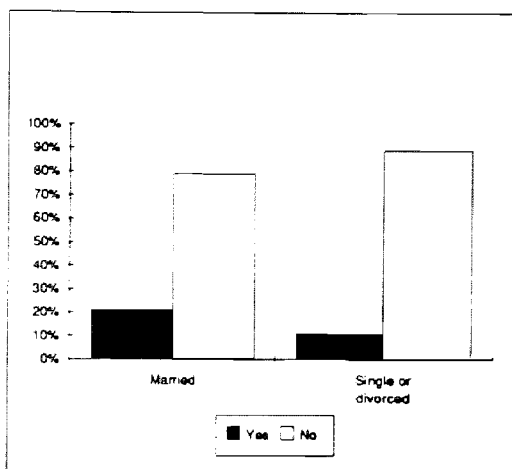
The participants were asked if they were ever concerned about their personal drinking behavior and their responses are represented in Figure 24. The participants' concern over their personal drinking was also related to their marital status and identification of an alcoholic parent (Figures 25 to 33).

**Figure 24.**  
**Drinking Concern**

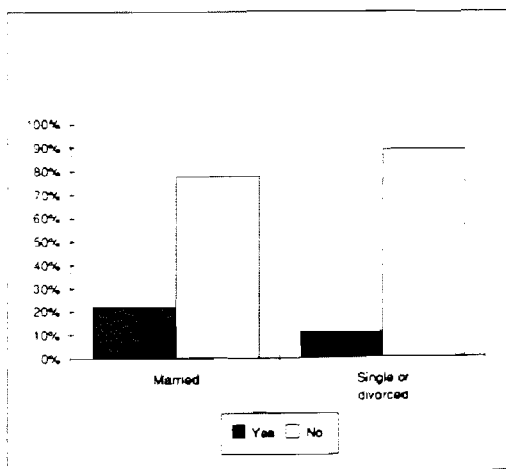




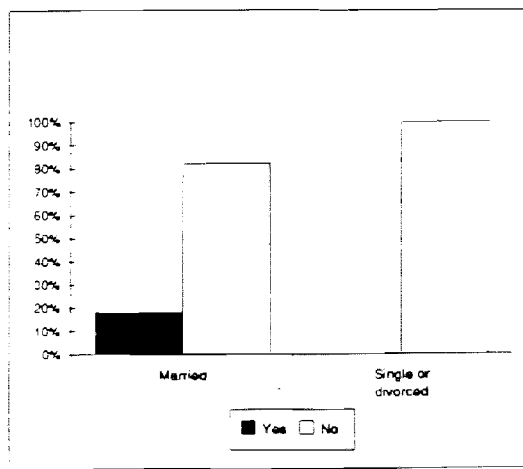
**Figure 25.**  
**Drinking Concern Related to**  
**Marital Status:**  
**Overall Sample**



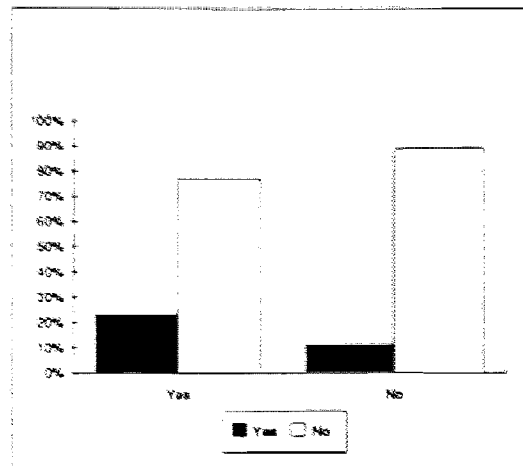
**Figure 26.**  
**Drinking Concern Related to**  
**Marital Status:**  
**Student Sample**



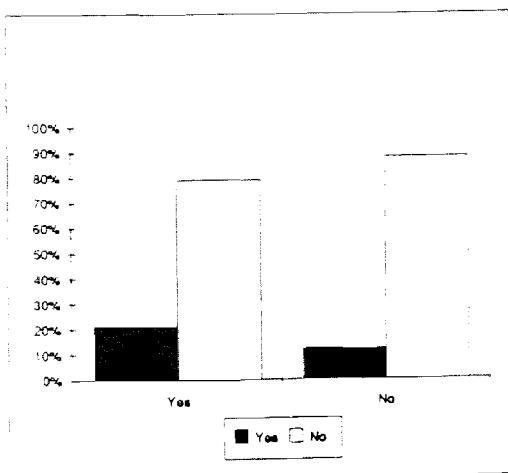
**Figure 27.**  
**Drinking Concern Related to**  
**Marital Status:**  
**Faculty Sample**



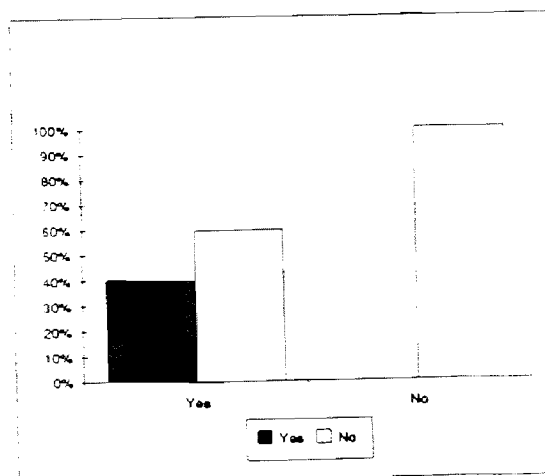
**Figure 28.**  
**Drinking Concern Related to**  
**Alcoholic Father:**  
**Overall Sample**



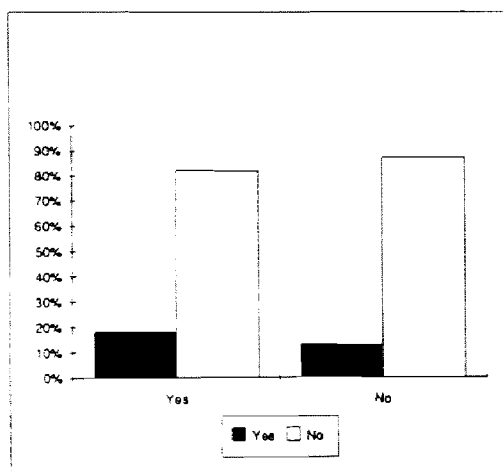
**Figure 29.**  
**Drinking Concern Related to**  
**Alcoholic Father:**  
**Student Sample**



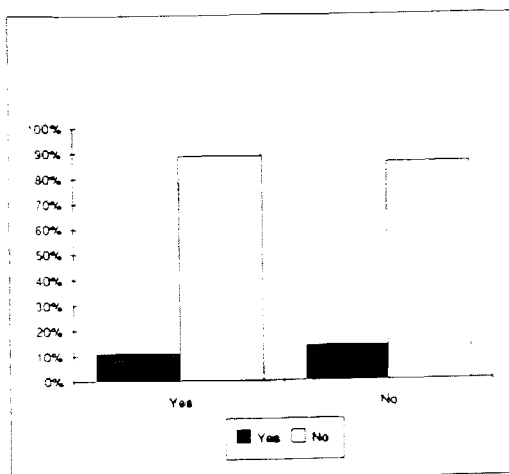
**Figure 30.**  
**Drinking Concern Related to**  
**Alcoholic Father:**  
**Faculty Sample**



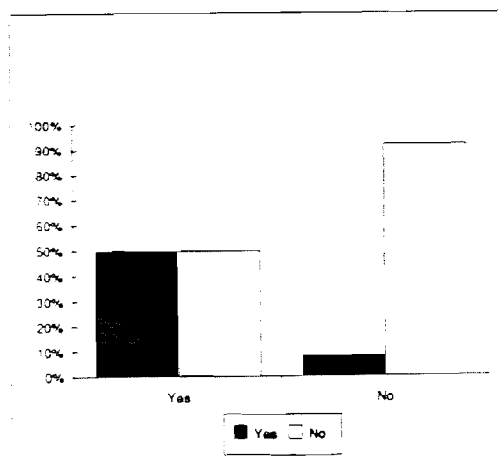
**Figure 31.**  
**Drinking Concern Related to**  
**Alcoholic Mother:**  
**Overall Sample**



**Figure 32.**  
**Drinking Concern Related to**  
**Alcoholic Mother:**  
**Student Sample**

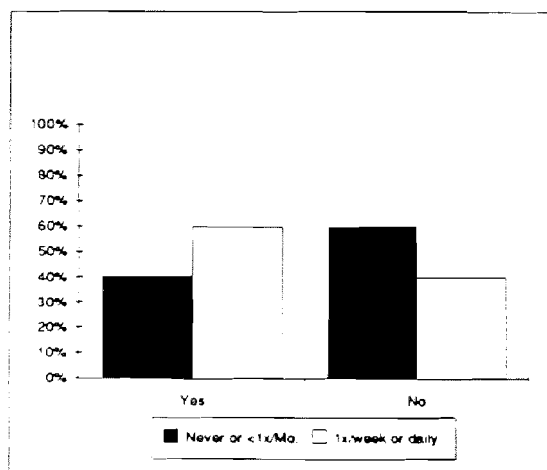


**Figure 33.**  
**Drinking Concern Related to**  
**Alcoholic Mother:**  
**Faculty Sample**

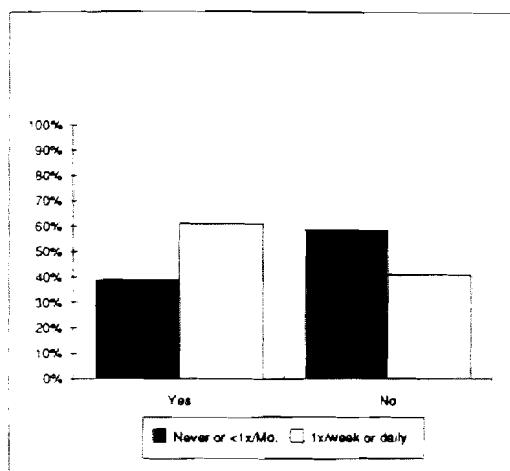


Finally, the participants' drinking patterns and concern over their personal drinking were compared. This data is represented in Figures 34 to 36.

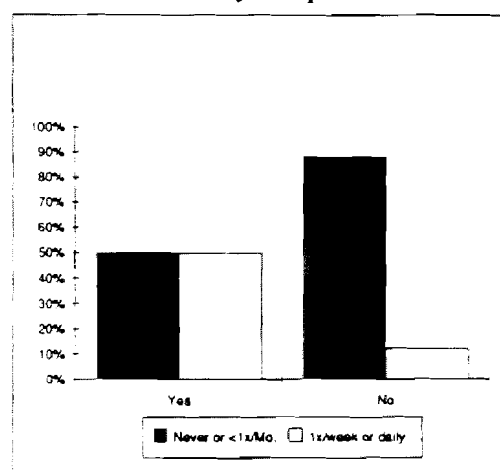
**Figure 34.**  
***Drinking Patterns Related to***  
***Drinking Concern:***  
***Overall Sample***



**Figure 35.**  
***Drinking Patterns Related to***  
***Drinking Concern:***  
***Student Sample***



**Figure 36.**  
***Drinking Patterns Related to***  
***Drinking Concern:***  
***Faculty Sample***



#### Analysis of C.A.S.T. (Jones, 1981) Scores

For the purpose of this analysis, the participants' ages were classified according to above the mean or below the mean. A *t* test was used to determine if there was a difference between the participants' mean score on the C.A.S.T. (Jones, 1981) as a function of their age, personal drinking patterns, concerns over personal drinking patterns or the participant's status (faculty member or student). These variables did not have a significant effect on the individual's total C.A.S.T. (Jones, 1981) score.

An additional *t* test was used to determine if there was a difference in the participants' total C.A.S.T. (Jones, 1981) score and the identification of an alcoholic parent. Participants who identified their father as alcoholic were compared with those who denied concern for an alcoholic father in the overall sample and in both the faculty and student samples. The same procedure was

carried out in the overall and student samples in regard to an alcoholic mother. There were only two faculty members who identified their mother as alcoholic and this number was not appropriate for a *t* test. The total C.A.S.T. (Jones, 1981) score was significantly greater when a parent was identified as alcoholic. The results of these *t* tests are represented in Table 1.

Table 1  
Mean Score as Identified by Alcoholic Parent

<u>Identified</u> <u>Parent</u>	<u>Mean Score</u>		
	<u>Overall</u> <u>Sample</u>	<u>Faculty</u> <u>Sample</u>	<u>Student</u> <u>Sample</u>
Father	13.62*	18.50***	12.87*
Mother	18.36*		16.22**

(\**p*=.0001; \*\**p*=.001; \*\*\**p*=.005)

For the purpose of further analysis, the participants who were divorced were grouped with the participants who were single; participants who never drank were again grouped with the participants who drank less than once a month; and those who drank daily were grouped with those who drank weekly. A chi-square analysis was used to determine whether these variables were dependent upon the participants' age, gender, status (student or faculty), identification of an alcoholic parent or the participants' concern over personal drinking patterns. All data were analyzed as a combined group, and again as either student or faculty.

Drinking Patterns Faculty and student patterns were not dependent on age, gender, marital status, concern about personal drinking behavior or the identification of either parent as an alcoholic.

Concern Over Personal Drinking Patterns Drinking concern was not dependent on status (student or faculty), age, gender, or drinking patterns. There was, however, significantly more concern about personal drinking patterns among the married participants than among the unmarried participants ( $p=.04$  with 1 degree of freedom) in the combined sample; no significance when examining faculty or students individually.

An additional chi-square analysis revealed a significantly greater concern about personal drinking patterns when a father was identified as alcoholic in the overall and faculty groups ( $p=.03$ ) but not in the student group.

## CHAPTER FIVE

### Discussion and Conclusion

The purpose of this study was to identify the incidence of instructors and students in one nursing program who are adult children of alcoholics (ACOAs). Additional variables and their association with the scores on the C.A.S.T. (Jones, 1981) were also investigated. These variables included the participant's age, marital status, drinking patterns and whether or not the individual had a concern over their personal drinking patterns.

A convenience sample of all the faculty and students employed or enrolled in a Midwestern diploma program during the fall semester of 1991 was used. All faculty attending the first faculty meeting of the fall semester, and all students attending classes the first day of the fall semester were asked to participate. Participation was voluntary and permission to participate was given by returning the completed surveys.

The participants who were present and chose to participate in the surveys included 17 faculty members and 201 students. This was a 47.22% response rate for the faculty and a 90.95 % response rate for the students with an overall response rate of 84.82%. Participants who did not include all the demographic or self-report data were included in the study if the C.A.S.T. (Jones, 1981) was completed.

#### C.A.S.T. (Jones, 1981) Scores.

It has been indicated in the literature that there is a disproportionately high percentage of ACOAs in nursing and other helping professions. Studies on



ACOA's, however, are limited and minimal study has focused on ACOA's in nursing (Fisher, 1987/1988). There were not any studies available related to nursing educators and administration. Any survey on alcoholic patterns is limited by the strong use of denial common in families of alcoholics. This study indicated that 23% of the students and 29.41% of the faculty in one Midwestern diploma school of nursing had C.A.S.T. (Jones, 1981) scores of 6 or greater which suggests being an adult child of an alcoholic (ACOA). Sixteen (8%) students and one faculty participant had a C.A.S.T. (Jones, 1981) score of 2-5, which indicates having a parent with problem drinking. Fifty-one (23%) of the overall participants had C.A.S.T. (Jones, 1981) scores of 6 or greater, and 17 (8%) had scores of 2-5.

The results of this study compare with the studies of other researchers. Haack and Harford (1988) indicated a total of 29% of nursing students were ACOA's. Pilat and Jones (1984/1985) found that 25.5% of a group of students in the helping professions, 28.4% of experienced helping professionals and 46.2% of miscellaneous therapists were ACOA's. Studies with other college students show incidence of ACOA's of 14.2% (Claydon), 15.57% (Knoblauch & Bowers, 1987) and 18% (Berkowitz & Perkins).

A 23% rate for students and 29% rate for faculty who classify as ACOA's should be a concern for faculty and nursing administrators. Growing up in an alcoholic home affects an individual's personality and may affect the individual's well being as well as his or her performance. Personality characteristics are essential to the nurse's role as assessor, teacher, planner, counselor and caregiver.

Some ACOAs may have developed strengths while growing up in a home where alcohol was abused; others may be resolving the problems of their background; others may have difficulty interacting with others. Being an ACOA may influence an educator's teaching style or influence his or her roles as advisor or counselor.

An increased awareness of the incidence of ACOAs may increase sensitivity to the behaviors of these individuals. Nurses who are ACOAs have a responsibility to change behavior that may be harmful to themselves or others. Nurse educators must be aware of conditions that affect students' learning. Educators cannot overlook the unique characteristics that may be present in students who are ACOA.

Further analysis of C.A.S.T. (Jones, 1981) scores in relation to personal variables revealed the C.A.S.T. (Jones, 1981) scores were not related to age, sex, personal drinking patterns, personal concern over drinking patterns or status as student or faculty member. The total C.A.S.T. (Jones, 1981) score was significantly greater when a parent was identified as an alcoholic. It is reasonable that if a parent is suspected of being an alcoholic more of the behaviors included on the C.A.S.T. would be present.

#### Drinking Patterns

Previous studies (Black et al., 1986; Claydon, 1987) have indicated a higher percentage of alcoholics among ACOAs than nondrinking families. Haack and Harford (1988) indicate a higher level of alcohol use among daughters of alcoholic fathers than daughters of alcoholic mothers. This study did not identify

any significant difference in drinking patterns among participants who were classified as ACOA, those who identified a parent as alcoholic or among the other variables. It is possible that denial used by families of alcoholics biased the reporting. It may, however, indicate that early exposure to alcoholic behavior in parents produces an awareness to drinking in moderation.

#### Drinking Concern

A significant increase in concern over personal drinking may relate to problem drinking. This study indicated significantly greater concern about personal drinking patterns among the overall participants and throughout the faculty sample when a father was identified as alcoholic. It may be that the participant had been exposed to behaviors that increased sensitivity to alcoholism. It is also possible that the results were a statistical error; these results could happen by chance alone 3 times in 100. In light of Haack and Harford's (1988) study on increased alcoholism among daughters of alcoholic fathers, courses on the process of addiction and the possibility the illness may be inherited would be beneficial. Because there was not any significantly greater concern among students, it may also be related to a greater awareness developed through maturity or additional education.

There was also significantly greater concern about personal drinking patterns among the married participants in the overall sample, but not in the student or faculty samples. A concern among married students is a dilemma because there was no significant increase between drinking patterns and marital status, age or concern, or between drinking concern and age, gender or status as a

student or faculty member. It may be that these results, too, were due to a statistical error and happened by chance alone ( $p=.04$ ). The social life of single adults is often accompanied by the use of alcohol and perhaps frequent drinking is expected behavior. Conceivably, marriage brings an increased maturity and awareness of a different lifestyle. An increase in concern among the married participants could also introduce the possibility of influence by a spouse. Lack of concern does not indicate lack of problem drinking, however, and institutions of health care have a responsibility to educate regarding problems associated with alcohol abuse.

#### Implications for Nursing Practice

This study contributed to the body of knowledge on the incidence of ACOAs in one diploma school of nursing. The findings of this study provide information that needs to be considered by nursing students, educators, and administrators in the service setting. The findings of this study indicate that 23% of the students and 29% of the faculty in one Midwestern diploma school of nursing are ACOAs. An awareness of the strong use of denial by families of alcoholics may suggest that the incidence is even greater. These figures compare with other studies among helping professions; it is likely that the results could be generalized to other schools of nursing. Nurses need to know and understand how their behavior may influence others. Nursing could benefit from identifying and helping students and faculty who are ACOAs.

ACOA's generally appear self-reliant, perfectionistic and socially poised. They are not generally recognized or helped because many health and social

service professionals are not aware of the effects of parental alcohol abuse on the family. Education about alcoholism and its effects on the families is a key factor in identifying and helping this vulnerable group of individuals.

While ACOAs must always live with their background and vulnerability, recovery is possible and will also ensure continued personal growth (Gravitz & Bowden, 1984). Accepting the situation that may have hindered development can be the first step in identifying a problem. Intervention can then free the energy and attention previously required to maintain denial for a satisfying and enjoyable life.

Some ACOAs may not have mastered the critical tasks of development. Trust may be hampered when parenting is inconsistent and inadequate due to the problems of alcoholism (Beltsis & Brown, 1981). Trust is necessary for the growth of autonomy (Erikson, 1968). Autonomy and social integration are job concepts that are important for job contentment. When nurses have both, they are more satisfied, have more motivation and are more committed to work. Even when an individual has only autonomy or social integration, satisfaction, motivation and commitment are possible. When both autonomy and social integration are absent or low, individuals have less job satisfaction (McCloskey, 1990). It is worth considering that some dissatisfaction among students, faculty and nurses may be due to a developmental delay, lack of social skills or chronic dissatisfaction common to ACOAs. ACOAs' inability to communicate and express feelings, difficulty in relationships, work related problems (Black et al., 1986) and an inability to seek comfort and help from others may also contribute

to job dissatisfaction (Scavnicky-Mylant, 1990). In addition, ACOAs who played the role of "family hero" may develop "super-nurse" characteristics which may lead to job burnout (Selbach, 1990).

A poor professional image is another concern for nursing. ACOAs have been described as having low self-worth and shame (Berkowitz & Perkins, 1988; Clair & Genest, 1987; Talashek, 1987). It would be interesting to know whether these behaviors attribute to the profession's low self-esteem. It is worth considering whether there is a relationship among inability to trust and alienation from others, participation in professional organizations, professional job satisfaction and professional image.

Nurses need to be prepared with the ability to think critically, solve problems and be creative. Teachers are responsible for motivating students to meet their own learning needs (Busl, 1981). An oppressive, impoverished environment of an alcoholic home may decrease an ACOA's motivation to learn. When it is established that there is a significant incidence of ACOAs in a school of nursing, faculty and staff need to be given information that can increase sensitivity in the environment to problems typical of individuals from alcoholic families. An atmosphere of acceptance of the problems ACOAs may demonstrate could lead to referral for counseling for the individual who might otherwise drop out of school (Crawford & Phyfer, 1988).

It is interesting that there were not any studies available related to nursing educators and administration and how being an ACOA may affect teaching and advising. This study did indicate that 29% of the faculty at one school of nursing

are ACOAs. Before students can be helped, faculty who are ACOAs need to know and understand how their background may affect their teaching style.

Some suggestions for intervention programs for college and nursing students have been described. These interventions may generally be applied to faculty and administration. The first step is identification. Schools of nursing could implement screening procedures that would allow for early referral and treatment, thus promoting healthier psychosocial development. Many times individuals raised in a family where alcohol was abused may demonstrate acting out behavior, and are seen by housing personnel or campus security (Downing & Walker, 1987). Other ACOAs may have repeated illnesses and be seen by health services or have repeated absences. These individuals could be screened for parental alcohol abuse, with a focus on the effects on the individual rather than on the identification of the parent's problem (Biek, 1981).

ACOA's who learned to enable may have unexpressed anger and may have difficulty functioning. Also, in stressful situations ACOAs may have an occasional angry outburst, or even a brief episode of rage (Cummings, 1988). Well-informed faculty and administration can be sensitive to these issues.

ACOA's may have difficulty being assertive and need to be taught communication and assertiveness skills. Difficulty talking in a group setting may be a sign of low self-esteem, and developing trust with others can be a help. Instructors and administrators can support the growth of integrity by reinforcing the individual's sense of achievement, giving support and listening to his or her feelings (Wallhead, 1986). Finally, an instructor or administrator can be a role

model of healthy behavior (Tesson, 1990).

Another method of intervention is the use of support groups. A support group is an accepted method of intervention because it is a safe place to learn to trust and express feelings. ACOAs may attend a group and relinquish their roles, rely on others and develop an understanding of what has happened while growing up (Black, 1979). Relating to others in a group setting reduces the individual's feelings of isolation. The realization that one is not alone is a great relief and releases psychic energy that had been used to deny problems and maintain control of emotions (Gravitz & Bowden, 1984). Providing a list of the time and location of available support groups is needed. Nursing leaders may consider the implementation of support groups specific for individuals in the nursing profession.

Early intervention might also decrease the individual's risk of abusing alcohol. Black et al. (1986), Claydon (1987), Haack and Harford (1988) and Knoblauch and Bowers (1989) indicated a significant increase in alcoholism among ACOAs. The incidence of addiction in nursing cannot be taken lightly. Individuals and families in need of nursing services entrust their lives to and expect to be cared for by nurses. This trust requires nurses who are alert, patient, and in the best of mental and physical health. It is a grave disservice to the public if the people who are depended on, are themselves under the influence of alcohol. Reducing the risk of alcoholism may also lower the incidence of fetal alcohol syndrome and alcohol-damaged infants. In addition, identification of parental alcohol abuse may lead to beginning treatment for the entire family (Biek, 1981).



Ideally, intervention programs should begin in the early elementary years. When this has not happened, education should begin as soon as possible. One important aspect of education can be knowledge of alcohol in the nursing curriculum. In addition to content on alcoholism as a disease, the dynamics and treatment of alcoholism and the family patterns of addiction need to be taught. Faculty development programs could be provided to instructors and staff. Nursing educators could provide educational programs to nursing service.

Nurses are often in key positions to educate others and when knowledgeable about the problems alcohol abuse can cause can identify children in need and be able to help them. Finally, nurses can contribute information to organizations that work to help ACOAs (Arneson, Schultz & Triplett, 1987).

As recovery progresses, life becomes more rewarding and pleasureable for the ACOA. As ACOAs recover they develop a greater self-awareness, trust and respect for themselves and improved interpersonal relationships. These new behaviors lead to a more confident individual (Gravitz & Bowden, 1984). These changes will not only benefit the individual, but the profession of nursing and society as well.

#### Limitations of the Study

Several limitations may have influenced the results of this study. The region, age and size of the sample studied may have been a limitation. The subjects for this study were all enrolled or employed in a Midwest diploma school of nursing and their responses may not be representative of other regions. They may not represent the ethnic, socioeconomic or age groups of students and faculty

at other schools. Also, this was a private school with a religious orientation that may, or may not, affect the data received.

The testing situation was another limitation. The environment in which the participants completed the questionnaires was not consistent among all the participants. The verbal and written instructions were carefully reviewed with the staff selected to administer the questionnaires, but they may have incorporated individual styles. This may have influenced the participants' responses. The responses recorded by the participants may have demonstrated a desire to respond in a way acceptable to the investigators. The questionnaires were administered the first week of school which assured a greater participation. Additional anxiety related to a new school year may have influenced the testing situation.

The self-report tool may have been a limitation. The tool asked whether the respondent was concerned about his or her personal drinking patterns. A more thorough assessment tool, such as the Michigan Alcoholic Screening Tool (MAST), would more accurately determine whether there is an increase in alcoholism among the participants.

The small faculty sample was a limitation. More accurate analysis would be obtained using a larger sample.

#### Recommendations for Further Study

This study added to the body of literature on the incidence of ACOAs in nursing. It also contributed information regarding drinking behaviors of students and faculty at one Midwestern school of nursing. Further research needs to be done with students and faculty in different types of nursing programs, the service

setting and the incidence among members of professional organizations.

Utilizing several nursing schools would assure a larger sample size, especially among the faculty, and reduce the risk of errors in analysis.

Also, additional studies would be appropriate to determine whether there is a relationship between ACOAs and the incidence of substance abuse in nursing. A greater quantity of ACOAs would be found in an alcohol support group. A more thorough assessment tool, such as the Michigan Alcoholic Screening Test (MAST), would more accurately determine whether there is an increase in alcoholism among ACOAs. If there is a correlation, courses can be offered on legal issues of addictive behavior, as well as the addictive process, identification of the affected nurse, and intervention, treatment and recovery methods (Selbach, 1990).

Research on job satisfaction in nursing among ACOAs would be helpful. It would also be interesting to compare job satisfaction after recovery has begun. Examining the effects of various intervention strategies commonly utilized by ACOAs would be appropriate.

Future studies on how a nurse's personal involvement with alcoholism influences the nurse's ability to work with alcoholics or families of alcoholics could generate data that may, or may not, support the effectiveness of nurses who are ACOAs working in this field.

Most of the literature on ACOAs focused on the individual's misfortunes, but there are ACOAs who are doing very well. Evaluation of the sources of their strengths is also an important issue to study (El-Gueblay & Offord, 1977). These

individuals may be effective in helping other ACOAs identify and recover from the traumas from their childhood.

It is important that this forgotten area is studied. However, it can be potentially harmful to identify individuals as high-risk individuals. The goal must be to identify individuals as ACOA in an effort to break denial and contribute to the individual's development. The investigator realized this study was not expected to contribute any specific data about problems or interventions for ACOAs in nursing; it was expected to contribute to the body of knowledge about the incidence of ACOAs in one diploma school of nursing and offer insight into the needs of these individuals. The study did establish an awareness to continue to identify and assist these individuals.

## REFERENCES

- Arneson, S., Schultz., & Triplett (1987). Nurses' knowledge of the impact of parental alcoholism on children. Archives of Psychiatric Nursing, 1(4), 251-257.
- Barnes, J., Benson, C., & Wilsnack, S. (1979). Psychosocial characteristics of women with alcoholic fathers. Currents in Alcoholism, 6, 209-222.
- Beletsis, S. & Brown, S. (1981). A developmental framework for understanding the adult children of alcoholics. Focus On Women: Journal of Addictions and Health, 2, 187-203.
- Berkowitz, A. & Perkins, H. (1988). Personality characteristics of children of alcoholics. Journal of Counseling and Clinical Psychology, 2, 206-209.
- Biek, J. (1981). Screening test for identifying adolescents adversely affected by a parental drinking problem. Journal of Adolescent Health Care, 2, 107-113.
- Bingham, A. & Barger, J. (1985). Children of alcoholic families. Journal of Psychosocial Nursing, 23(12), 13-15.
- Black, C. (1979). Children of alcoholics. Alcohol Health and Research World, 23-27.
- Black, C. (1981). It Will Never Happen To Me. New York: Ballentine Books.
- Black B., Bucky, S., & Wilder-Padilla, S. (1986). The interpersonal and emotional consequences of being an adult child of an alcoholic. The International Journal of the Addictions, 21(2), 213-231.
- Busl, L. (1981). The teacher as manager of the learning environment. Journal of

- Nursing Education, 20(5), 42-47.
- Caroselli-Karinja, M. & Zboray, S. (1986). The impaired nurse. Journal of Psychosocial Nursing, 24(6), 14-19.
- Certo-Guinan, M. & Waite, L. (1991). The director of nursing and the chemically dependent nurse. Nursing Management, 22(4), 52-54.
- Claydon, P. (1987). Self-report alcohol, drug, and eating disorder problems among male and female collegiate children of alcoholics. Journal of American College Health, 36(2), 111-116.
- Clair, D. & Genest, M. (1987). Variables associated with adjustment of offspring of alcoholic fathers. Journal of Studies on Alcohol, 48(4), 345-355.
- Cook, J. & Fontaine, K. (1991). Essentials of Mental Health Nursing (2nd. ed.). Calif.: Addison Wesley.
- Crawford, R. & Phyfer, A. (1988). Adult children of alcoholics: a counseling model. Journal of College Student Development, 29, 105-111.
- Cummings, S. (1989). Adult children of alcoholics. College Psychotherapy. New York: Guilford.
- Downing, N. & Walker, M. (1987). A psychoeducational group for adult children of alcoholics. Journal of Counseling & Development, 65, 440-442.
- El-Guebaly, N. & Offord, D. (1977). The offspring of alcoholics: A critical review. The American Journal of Psychiatry, 134 (4), 357-365.
- Erickson, E.H. (1968). Identity: Youth and Crisis. New York: Norton.
- Falkman, S. & Lazares, R. (1980). An analysis of coping in a middle age

- community sample. Journal Health Social Behavior, 21, 219-239.
- Fischer, K. (1988). Adult children of alcoholics: Implications for the nursing profession. Nursing Forum, 23(4), 159-163.
- Gravitz, H. & Bowden, J. (1984). Therapeutic issues of adult children of alcoholics. Alcohol Health and Research World. 25-37.
- Haack, M. (1990). Collaborative investigation of adult children of alcoholics with anxiety. Archives of Psychiatric Nursing, 4(1), 62-66.
- Haack, M. & Harford, T. (1984). Drinking patterns among student nurses. The International Journal of the Addictions, 19(5), 577-583.
- Haack, M. & Harford, T. (1988). Nursing students with alcoholic fathers: Alcohol consumption and depressive symptoms. Issues in Mental Health Nursing, 9, 181-188.
- Harmesen, D. (1984). The impaired nurse: Growing concerns over chemical dependency. Imprint, 31(1), 29-32.
- Hetherington, S. (1988). Children of alcoholics: Mental health issue. Archives of Psychiatric Nursing, 2(4), 251-244.
- Hughes, J. (1977). Adolescent children of alcoholic parents and the relationship of Alateen to the children. Journal Counseling Clinical Psychology, 5, 946-947.
- Jack, L. (1990). Supportive therapy with college female ACOAs. NNSA News, 6-8.
- Jalowiec, A., Murphy, S., & Powers, M. (1984). Psychometric assessment of the Jalowiec Coping Scale. Nursing Research, 33(3), 157-161.

- Knoblauch, D. & Bowers, N. (1989). A therapeutic conceptualization of adult children of alcoholics. Journal of College Student Psychotherapy, 4(1), 37-52.
- Knoblauch, D. & Falconer, S. (1986). The relationship of a measured Taoist orientation to western personality dimensions. The Journal of Transpersonal Psychology, 18(1), 73-83.
- Landers, D. & Hollingdale, L. (1988). Working with children of alcoholics on a college campus: A rationale and strategies for success. Journal of College Psychotherapy, 2(3/4), 205-222.
- McCloskey, J. (1990). Two requirements for job contentment: Autonomy and Social integration. Image: Journal of Nursing Scholarship, 22(3), 140-143.
- Nardi, P. (1981). Children of alcoholics: A role-theoretical perspective. The Journal of Social Psychology, 115, 237-245.
- Pilat, J. & Jones, J. (1984/1985). Identification of children of alcoholics: Two empirical studies. Alcohol Health and Research World, 27-33.
- Pushkash, M. & Quereshi, M. (1980). Perception of self and others by male and female alcoholics. Journal Clinical Psychology, 36(2), 571-576.
- Rasmussen, J. (1964). Relationship of ego identity to psychosocial effectiveness. Psychological Reports, 815-825.
- Rearden, J. & Markwell, B. (1989). Self concept and drinking problems of college students raised in alcohol-abused homes. Addictive Behaviors, 14, 225-227.
- Scavnicky-Mylant, M. (1990). The process of coping among young adult children



- of alcoholics. Issues in Mental Health Nursing, 11, 125-139.
- Selbach, K. (1990). Chemical dependency in nursing. AORN, 52 (3), 531-542.
- Selzer, M. (1971). The Michigan alcoholism screening test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 12, 89-94.
- Sloboda, S. (1974). The children of alcoholics: A neglected problem. Hospital and Community Psychiatry, 25(9), 605-606.
- Talashek, M. (1987). Parental alcoholism and adolescent ego identity. Journal of Community Health Nursing, 4(4), 211-222.
- Tessoon, B. (1990). Who are they? Identifying and treating adult children of alcoholics. Journal of Psychosocial Nursing, 28(9), 16-21.
- Wallhead, E. (1986). Developmental crisis: Helping students grow. Nurse Educator, 11(3), 19-22.
- Wegscheider-Cruse, S. (1985). Choice Making. Fla.: Health Communications, Inc.
- Wittman, P. (1990). The relationship between choice of college major and prevalence of adult children of alcoholics. Journal of Allied Health, 245-250.
- Wong, J., Wong, S. & Menasah, L. (1983). A conceptual approach to the development of motivational strategies. Journal of Advanced Nursing, 8, 111-116.
- Woodside, M. (1986). Children of alcoholics: Breaking the cycle. Journal of School Health, 56(10), 448-449.
- Zenmore, R. (1983). Development of a self-report measure of depression proneness. Psychology Report, 47, 211-217.

# APPENDIX A

## C. A. S. T.

81

Please check the answers below that best describe your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or "No".

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Age: \_\_\_\_\_

Yes	No	Questions
___	___	1. Have you ever thought that one of your parents had a drinking problem?
___	___	2. Have you ever lost sleep because of a parent's drinking?
___	___	3. Did you ever encourage one of your parents to quit drinking?
___	___	4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
___	___	5. Did you ever argue or fight with a parent when he or she was drinking?
___	___	6. Did you ever threaten to run away from home because of a parent's drinking?
___	___	7. Has a parent ever yelled at or hit you or other family members when drinking?
___	___	8. Have you ever heard your parents fight when one of them was drunk?
___	___	9. Did you ever protect another family member from a parent who was drinking?
___	___	10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
___	___	11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
___	___	12. Did you ever wish your parent would stop drinking?
___	___	13. Did you ever feel responsible for and guilty about a parent's drinking?
___	___	14. Did you ever fear that your parents would get divorced due to alcohol misuse?
___	___	15. Have you ever avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
___	___	16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
___	___	17. Did you ever feel that you made a parent drink alcohol?
___	___	18. Have you ever felt that a problem drinking parent did not really love you?
___	___	19. Did you ever resent a parent's drinking?
___	___	20. Have you ever worried about a parent's health because of his or her alcohol use?
___	___	21. Have you ever been blamed for a parent's drinking?
___	___	22. Did you ever think your father was an alcoholic?
___	___	23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
___	___	24. Did a parent ever make promises to you that he or she did not keep because of drinking?
___	___	25. Did you ever think your mother was an alcoholic?
___	___	26. Did you ever wish you could talk to someone who could understand and help the alcohol related problems in your family?
___	___	27. Did you ever fight with your brothers and sisters about a parent's drinking?
___	___	28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
___	___	29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
___	___	30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

\_\_\_ TOTAL NUMBER OF "Yes" ANSWERS



### Camelot Unlimited

5 N. Wabash Avenue • Suite 1409 Dept 18 • Chicago, IL 60602 (312) 938-8861  
Copyrighted © 1983 by John W. Jones, Ph.D. - All Rights Reserved - V8/90

## APPENDIX B

1200 Pleasant Street, Des Moines, Iowa 50309, (515) 283-6212

82



### IOWA METHODIST HEALTH SYSTEM

---

July 19, 1991

Phyllis Swanson  
Division of Nursing  
Drake University  
220 Olin Hall  
Des Moines, IA 50311

RE: R & I Grant Request: #504 PS: SON

Dear Phyllis:

Your request was approved by the Research and Innovation Center Advisory Committee at its meeting on July 17, 1991. It is understood that you will use the informed consent process submitted with the application and that the study will be coordinated through Pam Jeffries of the School of Nursing.

Please keep the committee informed of the progress of your study and provide a copy of the results to the Research and Innovation Center at the conclusion of the study. At the conclusion of your study, we would be interested in having you make a presentation at a scheduled Research Interest Group Breakfast meeting. Please contact me to determine a mutually agreeable date.

Should you have any questions or concerns regarding this procedure, please contact me at 283-6761. Best wishes in the conduct of your study. If I can be of any assistance in the course of the study, please call.

Sincerely,

A handwritten signature in cursive script, appearing to read "Keith L. McRoberts".

Keith L. McRoberts, Ph.D. P.E.  
Director, Research and Innovation Center

KLM/cfw

cc: Juli Taylor, Accounting  
Ivan Lyddon, IMHF  
Pam Jeffries, School of Nursing  
Linda Brady, Ph.D.

LTR/AD07/KLM/SWANSON



5 NORTH WABASH AVE.  
SUITE 1409  
CHICAGO, IL 60602  
(312) 938-8661

July 12, 1991

Phyllis Swanson  
Drake University - Nursing  
5019 Lakewood Drive  
Norwalk, IA 50211  
(Invoice #5462)

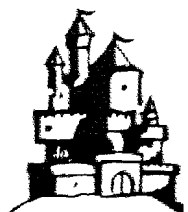
You have our permission, as publisher of the CAST, to use the CAST for your research at **Drake University** regarding "*The incidence of ACoAs in a Midwest Diploma School of Nursing*". If you come across any CAST studies not included in our research abstracts please send a copy of the study's abstract and title page.

You also have permission to include a copy of the CAST any in-class paper; including publication by the UMI Master/Dissertation Abstract service. Colleges generally send a student's research to UMI upon their graduation. If yours does not, we will pay half of the UMI publication costs. If you submit it for publication elsewhere, the CAST test must be removed and replaced with our company address for interested readers.

Please **send us the results** (including a printout of your raw CAST data) and a complete copy of your finished paper so that your findings may be included in future CAST test manuals. Please contact us if we can be of any further assistance.

Good luck,

Michael A. Lavelli, M.A.  
President, Camelot Unlimited



**APPENDIX D**

Please circle the correct answers.

**Marital Status**

Married

Single

Divorced

**Present Drinking Patterns**

Never Drink

Drink Socially -- less than once a month

Drink Socially -- at least once a week

Drink Daily

**Have You Ever Wondered If You Have a Drinking Problem?**

Yes

No

**APPENDIX E**

Dear Participant;

I am a graduate student in the department of Nursing at Drake University in Des Moines, Iowa. I am currently completing the requirements for my degree by conducting this study. Your participation is greatly appreciated. The study you are being asked to participate in, by completing these questionnaires, is designed to gather information about family patterns of drinking, and the incidence of adult children of alcoholics among nursing faculty and students in this school of nursing.

This study consists of two parts. The first section will consist of questions to determine demographic data. The second section is a Children of Alcoholics Screening Test (C.A.S.T.) (Jones, 1981). The C.A.S.T. (Jones, 1981) consists of 30 questions that can be answered with a "yes" or a "no". Please check the answer that best describes your feelings, behavior and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "yes" or "no".

When you have completed the survey, please place it in the container provided. There is no way that anyone will be able to tell who completed each test. Your decision whether or not to participate will not prejudice your present or future association with the school. Refusal to participate will not affect your grades in any way. Returning the completed questionnaires is your permission to participate.

If you have any questions about this study, please feel free to contact either myself (work, 247-3180; home, 287-8297) or my advisor at Drake University, Dr. Linda Brady (work, 271-2830; home 274-3081).

All aspects of the study have been designed to assure complete confidentiality. This school was chosen to participate through a convenience sample. There is no way to identify a completed questionnaire. The name of the school will not be identified in any writings about this study. Any information that is gained from this survey will be shared with the director of the school and the participants at their request at the completion of the study.

Thank you for participating in this study. If you have any questions, please ask. For your benefit, I am enclosing a list of ACOA support groups in the greater Des Moines area.

Sincerely,

Phyllis Swanson, R.N., BSN

**APPENDIX F**

Dear Participant,

I am a graduate student in the department of Nursing at Drake University in Des Moines, Iowa. I am currently completing the requirements for my degree by conducting this study. Your participation is greatly appreciated. The study you are being asked to participate in, by completing these questionnaires, is designed to gather information about family patterns of drinking, and the incidence of adult children of alcoholics among nursing faculty and nursing students. This study will all the faculty and students in this school of nursing.

This study consists of two parts. The first section will consist of questions to determine demographic data. The second section is a Children of Alcoholics Screening Test (C.A.S.T.) (Jones, 1981). The C.A.S.T. (Jones, 1981) consists of 30 questions than can bve answered with a "yes" or a "no". Please check the answee that best describes your feelings, behavior and experiences related to a parent's alcohol use. Take your time and be as accurated as possible. Answer all 30 questions by checking either "yes" or "no".

When you have completed the survey, please place it in the container provided before you leave. There is no way that anyone will be able to tell who completed each test. Your decision whether or not to participate will not prejudice your present or future association with the school. Returning the completed questionnaires is your permission to participate.

If you have any questions about this study, please feel free to contact either myself (work, 247-3180; home, 287-8297) or my advisor at Drake University, Dr. Linda Brady (work, 271-2830; home 274-3081).

All aspects of the study have been designed to assure complete confidentiality. This school was chosen to participate through a convenience sample. There is no way to identify a completed questionnaire. The name of the school will not be identified in any writings about this study. Any information that is gained from this survey will be shared with the director of the school and the participants at their request at the completion of the study.

Thank you for participating in this study. If you have any questions, please ask. For your benefit, I am enclosing a list of ACOA support groups in the greater Des Moines area.

Sincerely,

Phyllis Swanson, R.N., BSN

## ACOA Support Groups

Sunday	7:00 pm	Iowa Lutheran Hospital Univeristy at Penn *
	8:00 pm	Dallas County Outreach 2423 Willis, Perry
Monday	4:00 pm	Des Moines Area Community College Ankeny Campus* Call 964-6200 for room number.
	6:00 pm	Des Moines General Hospital 603 East 12th, 5th floor, Room 576
	7:30 pm	Ringgold County Hospital 211 Shellway Drive, Mt. Ayr
Tuesday	12:00 pm	Faith Lutheran Church 10359 University, Clive
	7:30 pm	Indianola Chapel of Faith Highway 65\69
	7:30 pm	First Congregational church 501 Montgomery, Creston
Wednesday	12:00 pm	Saint Paul's Episcopal Church 9th and High
	12:00 pm	Saint John's Lutheran Church 6th and Keo
	7:30 pm	Des Moines Campus Ministries 28th and University
Thursday	5:30 pm	Central Presbyterian Church For alternate lifestyles, but all are welcome.
	8:00 pm	First United Methodist Church 206 S.W. Walnut, Ankeny
Friday	7:00 pm	Beginners, Mercy Hospital Call for location.
	7:30 pm	Salem Lutheran Church Sycamore & Townline, Creston
Saturday	11:00 am	Des Moines Presbyterian Church 3829 Grand, Rm. 203, Enter through North door. Baby sitter provided. This is a newcomers meeting.*

\* Non-smoking

For further information, call ACOA Council, 262-7449, or write Adult Children of Alcoholics, P.O. Box 192, Des Moines, IA 50306-1921.